Case No. S122611

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

THE PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff and Respondent

v.

MAURICE G. STESKAL

Defendant and Appellant

On Appeal from the Superior Court of the State of California, County of Orange
Case No. 99ZF0023
The Honorable Frank F. Fasel, Judge Presiding

MENTAL HEALTH AMERICA AND NATIONAL ALLIANCE ON MENTAL ILLNESS' APPLICATION FOR LEAVE TO FILE AN *AMICI CURIAE* BRIEF IN SUPPORT OF DEFENDANT AND APPELLANT MAURICE G. STESKAL

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APPLICATION FOR LEAVE TO FILE *AMICI CURIAE* BRIEF IN SUPPORT OF DEFENDANT AND APPELLANT MAURICE G. STESKAL

Mental Health America and National Alliance on Mental Illness, pursuant to rules 8.630 and 8.520 of the California Rules of Court, respectfully request leave to file the enclosed *amici curiae* brief in support of Defendant/Appellant Maurice G. Steskal.[1] This application is timely submitted within thirty days of the date that Mr. Steskal filed his reply brief on the merits.

IDENTITY AND INTEREST OF *AMICI CURIAE* MENTAL HEALTH AMERICA AND NATIONAL ALLIANCE ON MENTAL ILLNESS

Mental Health America ("MHA") is a national membership organization comprised of individuals living with mental illness and their family members and advocates. Founded in 1909, MHA is the nation's oldest and leading community-based nonprofit mental health organization. It has more than 200 affiliates and is dedicated to improving the mental health of all Americans, particularly the 42 million people living with mental disorders. MHA's work is driven by its commitment to promoting mental health as a critical part of overall wellness, including prevention for all, early identification and intervention for those at risk, integrated health,

[1] The names of all counsel who authored the enclosed brief are identified on the cover of this Application and the brief. None of the named parties or third parties made monetary contributions to fund the submission of the enclosed brief.

behavioral health and other services for those who need them, and recovery. As an organization that is dedicated to protecting the interests of those who suffer from mental illness, many of whom are members of the organization, MHA has a direct interest in this case. Individuals with serious mental illness have difficulties navigating the criminal justice system and they are at a significant disadvantage when defending themselves in criminal cases. Moreover, since many individuals with serious mental illness, such as Mr. Steskal, do not have the capacity to understand or appreciate their criminal actions, subjecting them to the death penalty is tantamount to inflicting cruel and unusual punishment.

National Alliance on Mental Illness ("NAMI") is the nation's largest grassroots mental health organization. It is dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has a long history of advocating on behalf of people with mental illness involved with criminal justice systems and believes, as a matter of policy, that it is cruel and inhumane to sentence people with severe mental illness to death.

The questions presented in this case raise important concerns about whether and under what circumstances individuals suffering from serious mental illness should be put to death for their actions. MHA and NAMI have expert knowledge on how severe mental illness affects an individual's behavior and overall functioning. These organizations also have a comprehensive understanding of how the presence of mental illness may

impact an individual's ability to understand and navigate the criminal justice system and how their mental illness can affect their interactions and experiences while doing so. Thus, MHA and NAMI are uniquely positioned to offer the court insight into the issues raised in this case. Accordingly, MHA and NAMI respectfully request the court grant their request for leave to file the enclosed *amici curiae* brief in support of Mr. Steskal's request to set aside his death sentence.

Dated: October 28, 2016

Respectfully submitted,

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AMICUS CURIAE BRIEF

I. INTRODUCTION

This case presents a question of crucial importance for the citizens of the State of California suffering from severe mental illness, their families and friends, and for all others who are concerned about the protection of the Constitutional rights of these individuals to due process of the law and freedom from cruel and unusual punishment. If this Court upholds the trial court's imposition of the death penalty upon Appellant Maurice G. Steskal—a California citizen who suffers from severe mental illness currently and at the time of his crime—and continues to impose that penalty on others with mental illness, it will be affirming the infliction of cruel and unusual punishment upon a man who did not have the capacity to understand or appreciate his criminal actions as a result of his severe mental illness and for whom the death penalty is purely retributive, since it can have no deterrent effect.

Mr. Steskal is just one of many people incarcerated in America suffering from severe mental illness. An estimated 14 to 17 percent of the incarcerated population suffers from severe mental illness, a rate that is three to six times higher than in the general American population.[1] It is further estimated that at least 20 percent of people on death row have a severe mental illness.[2] Simply put, severe mental illness is prevalent in

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[1] *See* Lisa Davis, M.S.W. & John S. Brekke, Ph.D., *Social Networks and Arrest Among Persons With Severe Mental Illness: An Exploratory Analysis* (2013) 64 Psychiatric Services 1274, 1274.

[2] *See* Death Penalty Information Center, *Report: 75% of 2015 Executions Raised Serious Concerns About Mental Health or Innocence*, https://perma.cc/QQJ8-DDQD (finding that of the 28 people executed in 2015, 7 suffered from serious mental illness, and another 7 suffered from (Continued...)

America's criminal justice system—a system that fails to protect the rights and interests of these vulnerable individuals.

This brief aims to provide background and insight into the issue of severe mental illness amongst America's incarcerated offenders. It is the aim of Mental Health America ("MHA") and the National Alliance on Mental Illness ("NAMI") to deepen this Court's understanding of the nature of severe mental illness, its effect on the ability of individuals to effectively navigate the criminal justice system, and its effect on the psyche of jurors prescribing sentences for people suffering from mental illness. This brief also aims to highlight the consensus against the imposition of the death penalty on people with severe mental illness, and urges this Court to join the numerous mental-health advocacy organizations that support this position.

The brief proceeds as follows: First, it defines severe mental illness and examines the impact of these disorders on an individual's ability to function in a multitude of life spheres. Severe mental illness can adversely impact an individual's ability to complete day-to-day activities such as self-care, eating, drinking, bathing, and social interaction, and can diminish an individual's ability to think and communicate. A history of childhood maltreatment—one of harsh discipline or bullying, such as that experienced by Mr. Steskal at a young age—can exert an influence over the trajectory of severe mental illness throughout a person's lifetime.

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serious intellectual impairment or brain injury) (last visited Oct. 25, 2016); Robert J. Smith,, Sophie Cull, and Zoe Robinson, *The Failure of Mitigation?* (2014) 65 Hastings L.J. 1221, 1245 ("Over half (fifty-four) of the last one hundred executed offenders had been diagnosed with or displayed symptoms of a severe mental illness."); Brandi Grissom, *Trouble in Mind,* Texas Monthly 2013, https://perma.cc/JZ7K-ZFU6 ("On Texas's death row, more than 20 percent of the 290 inmates are considered mentally ill.") (last visited Oct. 25, 2016).

Next, the brief discusses Mr. Steskal's diagnosis of acute mental illness, specifically of delusional disorder and dysthymic (depressive) disorder, by Dr. Roderick Pettis. Dr. Pettis concluded that Mr. Steskal suffered from a psychotic break from reality on the date of the homicide—testimony which was uncontroverted at trial. The brief focuses on the nature of delusional disorder, specifically, and discusses why this type of severe mental illness is especially difficult to diagnose and treat. For example, the secrecy and suspicion caused by delusional disorder reduces the likelihood that those suffering from this illness will affirmatively seek help and the individual's implicit belief in their delusions reduces the likelihood that they will accept help when offered. Thus, individuals who suffer from delusional disorder, like Mr. Steskal, are at a heightened state of vulnerability as a result of their illness going undiagnosed and unchecked.

With this background of severe mental illness and its symptoms in mind, the brief next turns to the myriad difficulties faced by people with severe mental illness in navigating the criminal justice system. The brief specifically highlights the difficulties experienced by people with severe mental illness in handling aggressive police interrogation tactics and invoking or waiving Miranda rights. The significance of these disadvantages cannot be overstated. The right to counsel, the right to remain silent, the right to be free from coercive, abusive, or manipulative tactics by law-enforcement authorities—these are basic Constitutional rights that are subject to safeguards in America's criminal justice system. Yet the mental deficiencies of those with severe mental illness render them incapable of exercising these rights or understanding the safeguards put in place to protect them. As a result, people with severe mental illness are disproportionately more likely to provide false confessions during the

interrogation process—a simply unacceptable consequence of the system's failure to adequately address the needs of these individuals.

Next, the brief addresses the double-edged sword of introducing evidence of mental illness for mitigation purposes. Individuals are constitutionally entitled to present mitigating evidence during the sentencing phase of trial. But people with mental illness are faced with the reality that juries, and people in general, tend to falsely associate mental illness with future dangerousness or violence. Thus, a capital defendant with severe mental illness is faced with an impossible choice: refrain from exercising his right to introduce evidence of his mental illness as a mitigating factor or introduce this evidence and risk that the jury, relying on its biases, fears, and false perceptions, will use it as an aggravating factor in determining his punishment.

Ultimately, based on the increased vulnerability of people with mental illness who are sucked into the unforgiving current of the criminal justice system, the brief urges this Court to adopt the view of MHA, NAMI, and the mental-health advocacy community, including the American Bar Association, the American Psychological Association, and the American Psychiatric Association: that the death penalty should not be imposed on individuals with severe mental illness.

II. SEVERE MENTAL ILLNESS DEFINED

It is essential to understand the nature of severe mental illness itself in order to understand its effect on a capital defendant's ability to stand trial or execution. Severe mental illness, such as delusional disorder, can severely impact an individual's ability to function. It affects an individual's ability to think, communicate, and carry out basic day-to-day activities such as self-care, eating, drinking, bathing, and social interaction. Delusional disorder, from which Mr. Steskal suffers, presents a further challenge in

that it is both hard to diagnose and hard to treat—making it especially difficult to handle in the context of capital trials.

A. Severe Mental Illness Generally

A mental disorder is defined as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning."[3] The severity of mental illness—which may manifest as psychosis—is measured by the impact of the disorder on functioning.[4] Severe mental illness may include symptoms of delusions, hallucinations ("perception-like experiences that occur without an external stimulus"), extremely disorganized thinking, pervasive avoidance behaviors, and significant disruption of consciousness, memory, and perception of the environment.[5]

As a result of these symptoms, the presence of severe mental illness can have a devastating impact on a person's ability to function in a multitude of life spheres. People with severe mental illness may have

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[3] Diagnostic and Statistical Manual (5th ed. 2013) § I (Use of the Manual) (Am. Psychiatric Ass'n) [hereinafter DSM-V-TR], *available at* http://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596 (last visited Oct. 25, 2016). The DSM-V is the standard classification of mental disorders used by mental health professionals in the United States.

[4] *See* Jennifer Sánchez, Michael P. Frain, Jill L. Bezyak, Timothy N. Tansey &David A. Rosenthal, *Predicting Quality of Life in Adults With Severe Mental Illness: Extending the International Classification of Functioning, Disability, and Health* (2016) 61 Rehab. Psych. 19, 20. ("People with [severe mental illness] experience both a mental illness *and* a functional disability … and often have a long history of hospitalizations or intensive outpatient treatment due to severe psychosocial dysfunction …") (citations omitted).

[5] *See* DSM-V-TR, *supra* note 3, at § II.02 (Schizophrenia Spectrum and Other Psychotic Disorders); § II.05 (Anxiety Disorders); § II.08 (Dissociative Disorders).]

difficulties completing everyday activities "such as eating, dressing, and bathing" and "instrumental activities of daily living ... such as driving, budgeting, and medication management...."[6] Some people with mental illness experience difficulty communicating coherently.[7] Like bodily injury, childhood trauma can trigger a biological response, such as heightened inflammation levels in adults.[8]

While some mental disorders have a hereditary basis, environmental factors also exert an influence over the trajectory of mental illness throughout a person's lifetime.[9] Childhood maltreatment, such as "harsh discipline, disruptive caregiver changes, physical abuse, and sexual abuse" and bullying can lead to the development of mental health conditions in combination with other factors, such as heredity.[10] Such maltreatment is a predictor of "both high incidence and poor longitudinal course of several

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[6] Sánchez, *supra* note 4, at 20.

[7] *See* Thomas L. Patterson & Brent T. Mausbach, *Measurement of Functional Capacity: A New Approach to Understanding Functional Differences and Real-World Behavioral Adaptation in Those with Mental Illness* (2010) 6 Ann. Rev. Clinical Psychol. 139, 141 (in patients with schizophrenia, "activity limitations may manifest as difficulties in executing such functions as mental calculations (e.g., counting change) or producing logical, fluent, and goal-directed speech."). *See also* DSM-V-TR at §II.01 (Neurodevelopmental Disorders) (discussing developmental deficits which vary from specific limitations "to global impairments of social skills or intelligence").

[8] *See* Andrea Danese & Jessie Baldwin, *Hidden Wounds? Inflammatory Links Between Childhood Trauma and Psychopathology* (2017) 68 Ann. Rev. Psychol. 3.1, 3.12 (forthcoming 2017).

[9] *See* Daniel S. Pine & Nathan A. Fox, *Childhood Antecedents and Risk for Adult Mental Disorders* (2015) 66 Ann. Rev. Psychol. 459, 467.

[10] Danese, *supra* note 8, at 3.12.

psychiatric disorders," such as depression, schizophrenia, and bipolar disorder.[11]

B. Appellant's Severe Mental Illness

As discussed in Appellant's Opening Brief, substantial, uncontroverted evidence presented at Appellant Maurice Steskal's trial demonstrates that, at the time he committed the capital offense of which he was convicted, Mr. Steskal was suffering from severe mental illness.[12] After an extensive evaluation, Dr. Roderick Pettis, a clinical and forensic psychiatrist, concluded that Mr. Steskal was psychotic.[13] Dr. Pettis' comprehensive forensic evaluation of Mr. Steskal's mental condition included a review of Mr. Steskal's school and medical records, police reports, eight hours of interviewing with Mr. Steskal, and interviews with Mr. Steskal's family, friends, and former school teachers.[14]

Specifically, Dr. Pettis diagnosed Mr. Steskal with delusional disorder, persecutory type (a schizophrenic spectrum illness), as well as dysthymic (*i.e.,* depressive) disorder, and schizotypal personality disorder.[15] Dr. Pettis specifically cited to Mr. Steskal's history of abuse throughout his childhood and adolescence—at the hands of his father, older brother, various other family members, and schoolmates—in making this diagnosis.[16]

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[11] *Id.* at 3:3.

[12] *See* Appellant's Opening Br. at 151.

[13] *See id.* at 50.

[14] *See id.*

[15] *See id.* at 50-51.

[16] *See id.* at 51-56. Both Dr. Pettis and Dr. Robert Asarnow, Ph.D., a neuropsychologist who evaluated the appellant, determined that Mr. Steskal did not exhibit any signs of malingering. *See id.* at 52; 61; 66-68.

Based on his examination of the trial materials, his comprehensive interview with Mr. Steskal, and his overall diagnosis of Mr. Steskal's mental health, Dr. Pettis concluded that on the date of the crime, Mr. Steskal was suffering from a psychotic break with reality, which involved delusions caused by his severe delusional disorder.[17]

C. Difficulties Diagnosing and Treating Delusional Disorder

1. Diagnosis Among the General Population

Delusional disorder, with which Mr. Steskal has been diagnosed, is difficult to diagnose when an individual does not have access to a thorough mental-health evaluation,[18] due to the nature of the delusions at the center of the illness. A delusion is defined as "a belief that is held with strong conviction despite evidence disproving it that is stronger than any evidence supporting it."[19] This differs from a mere "erroneous belief caused by incomplete information (misconception or misunderstanding), deficient memory (confabulation) or incorrect perception (illusion)."[20] While delusions may feature in both delusional disorder and schizophrenia, these are two separate and distinct schizophrenia spectrum disorders.

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[17] *Id.* at 122-23.

[18] This section discusses the difficulty of diagnosing delusional disorder among individuals who are existing in society and going about their lives undisturbed and unexamined. The ability to diagnose the disorder is different in the context of prisoners, where the circumstances allow for the prisoners to be thoroughly examined and evaluated. In fact, Mr. Steskal received his first and only mental health evaluation and diagnosis once in the custody of the State of California. Ultimately, mental health professionals, when given the opportunity, have the tools required to diagnose this condition—as Dr. Pettis' diagnosis of Mr. Steskal demonstrates.

[19] Miles E. Drake Jr., M.D., *Delusional Disorder DSM-5 297.1 (F22)*, Theravive, http://www.theravive.com/therapedia/Delusional-Disorder-DSM--5-297.1-(F22) (last visited Oct. 25, 2016).

[20] *Id.*

A delusion, by nature, presents obstacles to diagnosis, as a person with a delusion is unlikely to seek help due to a basic and deep-seated mistrust of other people:

> Despite profound conviction about the delusion, the patient is often secretive or suspicious in discussing it. Delusional patients tend to be oversensitive and humorless, especially regarding the delusion. The belief is central to the patient's existence, and questioning it elicits an inappropriately strong emotional reaction. The belief is nevertheless unlikely, and not in keeping with the patient's social, cultural or religious background. The patient is highly invested emotionally in the belief, and other elements of the psyche may be overwhelmed.[21]

This element of secrecy and suspicion in discussing the delusion, in particular, reduces the likelihood that those suffering from delusional disorder will affirmatively seek help for their disorder,[22] thereby making diagnosis all the more difficult to ascertain.

Another factor that makes diagnosis of delusional disorder difficult without a thorough mental-health evaluation is that a person with a delusion often lacks the insight to recognize that he or she has a disordered mental state. Individuals with delusional disorder "may not feel the need for treatment and may resist the suggestions of others that they seek psychiatric attention" because they implicitly believe in their delusions.[23]

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[21] *Id.*

[22] *See id.* ("Delusional disorder is infrequent in psychiatric practice, possibly because … those who believe implicitly in their delusions may not feel the need for treatment and may resist the suggestions of others that they seek psychiatric attention.").

[23] *Id.*

Furthermore, many individuals with delusional disorder "are able to function tolerably well despite their delusions."[24] This is particularly the case when the individual does not have multiple delusions, but only one long-standing delusion.[25] Mr. Steskal, for instance, was able to function in society for 39 years, despite his severe mental illness.[26] But when he was confronted by Deputy Riches while in the throes of his long-standing delusion, *i.e.,* that he was being monitored by the government and law enforcement,[27] and the Orange County Sherriff's Department in particular,[28] he suffered a psychotic break and actually but unreasonably believed that he had to shoot Deputy Riches to defend himself.[29]

2. Treatment

Once diagnosed, delusional disorder is difficult to treat due to the fixed nature of delusions. Delusions are, by definition, "false beliefs that

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[24] *Id. See also* DSM-V-TR at §II.02 ("A common characteristic of individuals with delusional disorder is the apparent normality of their behavior and appearance when their delusional ideas are not being discussed or acted on.").

[25] *See* M. Skelton, W. Khokhar & S.P. Thacker, *Treatments for delusional disorder,* The Cochrane Collaboration, (May 22, 2015), http://www.cochrane.org/CD009785/SCHIZ_treatments-for-delusional-disorder ("Delusional disorder is a mental illness in which long-standing delusions (strange beliefs) are the only or dominant symptom."). *See also* DSM-V-TR at §II.02 ("The essential feature of delusional disorder is the presence of one or more delusions that persist for at least 1 month (Criterion A).... Apart from the direct impact of the delusions, impairments in psychosocial functioning may be more circumscribed than those seen in other psychotic disorders such as schizophrenia, and behavior is not obviously bizarre or odd (Criterion C).").

[26] *See* Appellant's Opening Br. at 189.

[27] *See id.* at 27; 59.

[28] *See id.* at 81.

[29] *See id.* at 99. *See also id.* at 113-14.

do not change even with proof that the beliefs are not true, no matter what others may say."[30] Thus, even if a person with delusional disorder can understand conceptually that others believe their delusion to be a false belief, they are not convinced that the delusion is false.[31] "The often-formidable internal logic of the delusional system, even if wrong, may ... militate against treatment adherence."[32] This is further exacerbated when one with delusional disorder maintains normal functioning most of the time.

Delusional disorder is also difficult to treat, pharmacologically or otherwise, due to a dearth of research in this area. For example, research tends to examine delusions within the context of a neurological disorder, such as dementia, as opposed to delusional disorder.[33] In addition, studies do not single out delusional disorder for focused inquiry: "[D]elusional disorder is rarely studied as a separate entity; most drug studies subsume delusional disorder as one in a range of psychotic spectrum disorders, and no sound randomized clinical trials for delusional disorder appear in the literature."[34]

The manner in which psychiatrists have conceptualized delusional disorder also does not lend itself toward straightforward treatment. "[T]he

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[30] Am. Psychiatric Ass'n, *Understanding Mental Disorders* 29 (2015).

[31] *See* DSM-V-TR at §II.02 ("Individuals with delusional disorder may be able to factually describe that others view their beliefs as irrational but are unable to accept this themselves (i.e., there may be 'factual insight' but no true insight).").

[32] Drake, *supra* note 19.

[33] Morgan T. Sammons, *Pharmacotherapy for Delusional Disorder and Associated Conditions* (2005) 36 Professional Psychology: Research and Practice 476, 476.

[34] *Id.*

disorder itself is rather poorly defined, and the ability to make a distinction between variants of delusional disorder or between delusional disorder and other forms of mental disorder (most commonly psychosis but also depression, body dysmorphic disorder, or severe obsessive-compulsive disorder) may be clinically challenging."[35] Researchers may be further discouraged from initiating or discovering treatment for the disorder due to a perceived uphill battle, as "delusional disorder is relatively uncommon and has been regarded as notoriously difficult to treat with any intervention."[36]

III. SEVERE MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM: CHALLENGES AND CONSIDERATIONS

People with serious mental illness have difficulties navigating the criminal justice system and are at a substantial disadvantage in defending themselves or participating meaningfully in their defense when faced with criminal charges—particularly those that put them at risk for the death penalty. For example, a mental illness may affect the voluntariness or reliability of a person's statements during police interrogation and could increase the likelihood of false confessions.[37] Mental health conditions can also compromise a person's competence to stand trial and to validly waive their rights.

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[35] *Id.*

[36] *Id.*

[37] *See* William C. Follette, Deborah Davis, & Richard A. Leo, *Mental Health Status and Vulnerability to Police Interrogation Tactics* (Fall 2007) 22 Crim. Just. 42, 46-49. As far as the record shows, this was not an issue with Mr. Steskal's case specifically, but it is an issue that frequently arises in capital cases involving defendants with mental illness.

Due to the challenges in detecting and treating delusional disorder, and the obstacles presented by the symptoms of the disorder, capital defendants with delusional disorder, like Mr. Steskal, are at a severe disadvantage when navigating the criminal justice system. The aforementioned distrust and paranoia that prevents individuals with delusional disorder from seeking treatment may become even more intensified in the midst of a capital trial.[38] Furthermore, the adversarial nature of litigation can hinder the formation of a necessary alliance between a person with delusional disorder and their defense counsel.[39] A capital trial, an inherently confrontational environment, may trigger sensitivities in a person with delusional disorder such that they mistrust even their own counsel.[40]

A. Difficulty Handling Aggressive Police Interrogation Tactics

Those suffering from severe mental illness are particularly vulnerable to police interrogation and are, thus, more likely to provide false

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[38] *See* A.B.A., *Diminished Culpability* (2006) 30 Mental and Physical Disability L. Rep. 62, 62, *available at* http://www.jstor.org/stable/20786772 (last visited Oct. 25, 2016) (describing the case of capital murder defendant Jackson Daniels, Jr., whose "paranoia made him distrust an attorney who had worked for most of his career as a prosecutor.... Trial counsel could not discuss strategies or obtain basic information from Daniels. This poor communication worsened during the penalty phase and prevented counsel from making a case in mitigation using Daniels's own words....").

[39] *See* Paul S. Appelbaum, M.D., *Imposed Insanity Defenses and Political Crimes* (2013) 64 Psychiatric Serv. 4, 4-5 (describing a study of defendants who had pursued the insanity defense in Colorado which found that the defense had been pled against the wishes of 32% of defendants interviewed).

[40] *See* A.B.A, *supra* note 38.

confessions.[41] To understand why this is so, it is important to first examine the form and function of interrogations—the purpose of which is to elicit incriminating statements, admissions, and confessions.[42] "Establishing psychological control is a critical element toward that end."[43] The interrogation process is designed to induce stress and aims to promote a sense of isolation and to increase anxiety associated with "denial relative to confession."[44] Police use a broad range of tactics to induce suspects to confess, including lying, feigning sympathy, offering a moral justification for the crime, presenting false or misleading evidence, and shifting blame.[45]

To successfully navigate the interrogation process, an individual must understand when a police officer is insinuating that they are guilty or trying to manipulate them.[46] The person must also have the ability and motivation to resist influence, to understand when to talk or remain silent, and to know how to answer questions.[47] Perhaps most importantly, the individual must understand that the potential long-term harm resulting from openly communicating with the police may outweigh the harm that can occur if they refuse to speak.[48]

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[41] *See* Follette, *supra* note 37, at 46-49.

[42] *See* Saul M. Kassin,Steven A. Drizin, Thomas Grisso, Gisli H. Gudjonsson, Richard A. Leo & Allison D. Redlich, *Police-Induced Confessions: Risk Factors and Recommendations* (Feb. 2010) 34 L. Hum. Behav. 3, 6.

[43] Allison D. Redlich, Ph.D. *Law & Psychiatry: Mental Illness, Police Interrogations, and the Potential for False Confessions* (Jan. 2004) 55 Psychiatric Servs. 19, 20.

[44] Kassin, *supra* note 42, at 6.

[45] *See* Redlich, *supra* note 43, at 20.

[46] *See* Follette, *supra* note 37, at 43.

[47] *See id.*

[48] *See id.*

Individuals with severe mental illness, however, may have difficulty understanding a significant number of these concepts due to symptoms such as deficiencies in intellectual and reasoning, lack of social skills, or the propensity to become easily confused.[49] Additionally, severe mental illness is often accompanied by false reality monitoring, distorted perception, poor self-control, and feelings of guilt.[50] Individuals with severe mental illness may also possess a range of psychiatric symptoms that make them more likely to agree with or to supply false information. For example, some individuals with mental illness have difficulties with assertiveness, which may preclude them from denying that they committed a crime, asking for an attorney, or telling a police officer that they are innocent when the police officer insists they are guilty.[51] Moreover, people with mental illness may not understand the adversarial nature of the interrogation process or be able to detect deception. Rather, the individual may think that the police officer is their friend or someone who understands their plight.[52] Accordingly, individuals with mental illness are disproportionately more likely to provide a false confession during the interrogation process, particularly in response to the pressure and coercive tactics characteristic of police interrogations.

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[49] *See* Kassin, *supra* note 42, at 30. *See also* Redlich, *supra* note 43, at 20. These symptoms can also impact the ability of a person with mental illness to understand the workings of the criminal justice system. *See* Jillian Peterson et al., *Understanding Offenders with Serious Mental Illness in the Criminal Justice System* (2016) 42 Mitchell Hamline L. Rev. 537, 550 (explaining that people with serious mental illnesses may have difficulty assisting their attorney in putting together a defense and fully understanding court plea bargains and court procedures).

[50] *See* Kassin, *supra* note 42, at 21.

[51] *See* Redlich, *supra* note 43, at 20.

[52] *Id.*

B. Difficulty Understanding Invocation or Waiver of Miranda Rights

Although Miranda rights are designed to protect individuals from the aforementioned coercive tactics that may occur during interrogation, these safeguards are insufficient to protect individuals with severe mental illness, who may have difficulty intelligently invoking or waiving these rights. To successfully invoke Miranda rights, an individual must understand what the rights are, why they are important, and the harm that can occur if they are not invoked.[53] As discussed, many people with severe mental illness suffer from cognitive impairments that include disorganized thinking, difficulty understanding, poor concentration, poor memory, difficulty expressing thoughts, and difficulty integrating thoughts, feelings, and behavior.[54] Thus, many individuals with mental illness do not have the requisite cognitive skills necessary to understand Miranda warnings and cannot fashion intelligent reasons for waiving the rights.[55] Miranda rights are therefore unlikely to protect people with severe mental illnesses from the dangers of coercive interrogations, such as the risk of false confessions.

IV. SEVERE MENTAL ILLNESS AND SENTENCING: MENTAL ILLNESS AS A MITIGATING FACTOR

While a capital offender is constitutionally entitled to present evidence of their mental illness as a mitigating factor during the sentencing

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[53] *See* Follette, *supra* note 37, at 43.

[54] *See id.* at 44-46.

[55] *See, e.g.,* Richard Rogers, Kimberly S. Harrison, Lisa L. Hazelwood & Kenneth W. Sewell, *Knowing and Intelligent: A Study of Miranda Warnings in Mentally Disordered Individuals* (2007) 31 L. & Hum. Behav., 401, 408-410 (conducting a study finding that only ten percent of individuals with mental illnesses had a good understanding of Miranda and that one fourth of the participants studied could not articulate a single reason he or she should exercise Miranda rights when interrogated).

phase of trial, "[t]he increased risk of violent outcomes that is associated with mental illnesses" creates a dilemma for the offender in this regard.[56] Rather than mitigate the sentence faced, evidence of mental illness can actually act as an aggravating factor due to the likelihood that jury members have false associations between mental illness and future dangerousness.[57]

A. The Right to Present Mitigating Evidence

At the penalty phase of trial, a capital defendant is constitutionally entitled to present "mitigating evidence," or any evidence that would serve as a basis for a life verdict rather than the death penalty.[58] Mitigating evidence can include evidence related to an offender's mental illness, youth,[59] history of emotional or physical abuse,[60] and relative lack of specific intent and involvement in the predicate offense.[61] The jury may consider any mitigating evidence it finds relevant and is instructed to weigh the mitigating factors presented by the defense against the aggravating

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[56] Sarah L. Desmarais Ph.D., Richard A. Van Dorn, Ph.D., Kiersten L. Johnson, MS, Kevin J. Grimm, Ph.D., Kevin S. Douglas, Ph.D., and Marvin S. Swartz, M.D., *Community Violence Perpetration and Victimization Among Adults With Mental Illnesses* (Dec. 2014) 104 Am. J. of Pub. Health 2342, 2342.

[57] *See* Ellen F. Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing* (Mar. 1989) 89 Colum. L. Rev. 291, 299.

[58] *See Lockett v. Ohio* (1978) 438 U.S. 586, 604 (holding that the Eighth and Fourteenth Amendments require that capital juries 'not be precluded from considering, *as a mitigating factor*, any aspect of a defendant's character or record and any of the circumstances of the offense that the defendant proffers is a sentence less than death").

[59] *See Eddings v. Oklahoma* (1982) 455 U.S. 104; *Lockett*, 438 U.S. at 597.

[60] *See Penry v. Lynaugh* (1989) 492 U.S. 302.

[61] *See Lockett*, 438 U.S. at 586.

factors presented by the prosecution.[62] Research shows, however, that evidence of mental illness is often not provided during sentencing[63] or is given too little weight by juries when it is provided.[64] More significantly, however, presentation of mental illness as a mitigating factor can be a double-edged sword for capital defendants because jurors often misperceive mental illness as aggravating evidence rather than mitigating evidence.[65]

B. The Double-Edged Sword of Presenting Mental Illness as a Mitigating Factor

People with severe mental illness are at risk of receiving harsher sentences because of the jury's negative perceptions of their mental health condition. Misperceptions, fears, and prejudices associated with mental illness are significant factors in jury verdicts for cases involving people with mental illness. For example, jurors often have false perceptions of the link between mental illness and dangerousness and also frequently

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[62] *See Stringer v. Black* (1992) 503 U.S. 222, 229; *Brown v. Sanders* (2006) 546 U.S. 212, 216-17; *see also* Katie Morgan & Michael J. Zydney Mannheimer, *The Impact of Information Overload on the Capital Jury's Ability to Assess Aggravating and Mitigating Factors* (2009) 17 Wm. & Mary Bill Rts. J. 1089, 1096-1097; William J. Bowers, *The Capital Jury Project: Rationale, Design, and Preview of Early Findings* (Fall 1995) 70 Ind. L.J. 1043, 1063.

[63] *See generally* The Charlotte School of Law, *Mental Illness and the Death Penalty in North Carolina* (May 2007), http://www.deathpenaltyinfo.org/CharlotteMI.pdf, 25 (last visited Oct. 25, 2016).

[64] *See* Am. Psychiatric Ass'n, *Diminished Responsibility in Capital Sentencing*, (2004) ("[M]any observers of capital sentencing proceedings, including participating psychiatrists, believe that juries tend to give too little weight to mitigating evidence of severe mental disorder, leading to inappropriate execution of offenders whose responsibility was significantly diminished by mental retardation or mental illness[.]").

[65] *See* Berkman, *supra* note 57, at 299.

misunderstand the role that mental illness plays in crimes.[66] This misunderstanding contributes to an environment of fear in which "prolonged periods of incarceration are seen as acceptable, even necessary, steps."[67] Jurors may believe that individuals with mental illness must be subjected to longer periods of incarceration—or even death—because they pose an ongoing danger to society and are incapable of being rehabilitated.[68]

The association between severe mental illness and an increased likelihood of violent behavior is misplaced, however.[69] While the rate of

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[66] *See generally* John F. Edens, Donna M. Desforges, Krissie Fernandez & Caroline A. Palac, *Effects of Psychopathy and Violence Risk Testimony on Mock Juror Perceptions of Dangerousness in a Capital Murder Trial* (Dec. 2004) 10 Psychol., Crime & L. 393, 393-412 (describing a study in which 238 mock jurors, when presented with two case summaries—one in which the prosecution presented evidence that the defendant suffered from a mental disorder and another, identical save for the absence of evidence that the defendant suffered from a mental disorder—rated the defendants with a mental disorder more likely to be violent in the future, even though testimony related to level of risk was constant); *see also* Heather Stuart, *Violence and Mental Illness: An Overview* (June 2003) 2 World Psychiatry 121, 123 (noting that "members of the public ... exaggerate both the strength of the relationship between major mental disorders and violence, as well as their own personal risk of being harmed by someone who is mentally ill); Liliana L. Jubilut, *Death Penalty and Mental Illness: The Challenge of Reconciling Human Rights, Criminal Law, and Psychiatric Standards* (2007) 6 Seattle J. for Soc. Justice 353, 377 (stating that juries lack understanding "of the real impact of mental illness on behavior").

[67] The Sentencing Project, *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription*, 8-9 (Jan. 2002).

[68] *See* Jubilut, *supra* note 66, at 377 (stating that jurors' decisions are often impacted by their perceptions of whether, and to what degree, a defendant feels remorse and that jurors may believe that a defendant's behavior in one situation will lead to future violence).

[69] *See* Stuart, *supra* note 66, at 121 (explaining that "mental disorders are neither necessary, nor sufficient causes of violence").

people living with mental illness in the United States is substantial, the rate of violence among those with mental illness is "marginal."[70] Research shows that only three to five percent of violent acts can be attributed to people with severe mental illness.[71] In fact, people with mental illness are far more likely to be victims of violent crime.[72] Mr. Steskal's case is consistent with these findings. Prior to killing Deputy Riches, Mr. Steskal did not have any history of committing violent acts towards others.[73] To the contrary, he was beaten by his father, mother, and brothers, and harassed by at least one police officer, yet did not display violent tendencies until his one and only crime.[74]

In deciding whether to present evidence of mental illness as a mitigating factor during sentencing, this false association between mental illness and dangerousness presents a conundrum. On the one hand,

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[70] Laurie R. Martinelli, J.D., June S. Binney, & Rebecca Kaye, J.D., *Separating Myth from Fact: Unlinking Mental Illness and Violence and Implications for Gun Control Legislation and Public Policy* (2014) 40 New Eng. J. on Crim. & Civ. Confinement 701, 703; s*ee also* U.S. Dep't of Health and Hum. Servs., *Mental Health: A Report of the Surgeon General* 7 (1999) (noting that there is a small connection between mental illness and violence). *See also* Mental Health America, Position Statement 72: Violence: Community Health Response (2014), *available at* http://www.mentalhealthamerica.net/positions/violence#_ednref18 (last visited Oct. 25, 2016) (citing landmark 2009 study by Elbogen et al., published in the Archives of General Psychiatry, which found that mental illness alone is not an adequate basis for a prediction of dangerousness).

[71] Jonathan M. Metzl, M.D., Ph.D., and Kenneth T. MacLeish, Ph.D., *Mental Illness, Mass Shootings, and the Politics of American Firearms* (Feb. 2015) 105 Am. J. Pub. Health 240,241.

[72] *Id.* at 242; Desmarais, *supra* note 56, at 2342. (noting that studies indicate that an adult with mental illness is 23 times more likely to experience violent victimization than a member of the general population).

[73] *See* Appellant's Reply Br. at 70.

[74] *See* Appellant's Reply Br. at 30; 33.

evidence of the illness can educate the jury as to the offender's culpability and/or ability to understand their actions, thereby showing that the severe mental illness is part and parcel of the crime, as is likely in Mr. Steskal's case. On the other hand, jurors may view the mental illness as an aggravating factor due to the false perceptions and biases commonly related to severe mental illness.

V. IMPOSITION OF THE DEATH PENALTY ON PEOPLE WITH SEVERE MENTAL ILLNESS SHOULD BE BARRED

As discussed, the criminal justice system does not effectively safeguard the rights of these individuals with severe mental illness as they endeavor to navigate the system—one which is not equipped to deal with the far-reaching effects of severe mental illness on an individual's ability to function. Further, a capital offender is at heightened risk of receiving the death penalty because jurors falsely associate mental illness with the risk of future dangerousness and consider evidence of mental illness to be an aggravating, rather than a mitigating, factor. Nor does the Constitutional requirement of "competency" to stand trial effectively protect the rights of people with mental illness. Ultimately—as the consensus amongst national mental health organizations demonstrates—the death penalty should not be imposed on individuals with mental illness.

A. The Failure of the System to Safeguard Offenders with Severe Mental Illness

The Constitution requires that a person be mentally competent to stand trial.[75] The baseline test for competency is whether a defendant has the present ability to consult with his lawyer with a reasonable degree of rational understanding and has a rational, as well as factual, understanding of the proceedings against him.[76] Although, by design, the requirement for competency safeguards offenders with severe mental illness (who, due to their illness, may not understand their actions or the proceedings against them), in reality, competency is a very low bar. Courts and juries routinely find that defendants with mental illness, including those with schizophrenia and severe delusions, meet basic competence requirements.[77]

B. The Consensus Among the Mental Health Community Against the Imposition of the Death Penalty on People With Severe Mental Illness

In *Atkins v. Virginia*, the United States Supreme Court found that a legislative or legal consensus can be reinforced by substantial evidence of a "broader social and professional consensus," which can include the official positions of professional "organizations with germane experience" and the

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[75] *See Indiana v. Edwards* (2008) 554 U.S. 164, 170 (noting that "the Constitution does not permit trial of an individual who lacks 'mental competency'").

[76] *See Dusky v. United States* (1960) 362 U.S. 402. *See also Edwards* 554 U.S. at 170. Even where a defendant is competent to stand trial, he may not be competent to represent himself, as that question is assessed under a separate standard. *See Edwards*, 554 U.S. at 177-178. Competency to waive counsel requires "significantly more mental capacity than competency to stand trial. *See* Christopher Slobogin, *Mental Illness and Self-Representation: Faretta, Godinez, and Edwards* (2009) 7 Ohio State J. Crim. L. 391, 400.

[77] *See* Michelle C. Goldbach, *Like Oil and Water: Medical and Legal Competency in Capital Appeal Waivers* (2000) 1 Cal. Crim. L. Rev. 2.

views of the international community.[78] Here, numerous organizations with germane expertise regarding mental illness, including a number of mental-health advocacy organizations, have adopted official positions opposing the imposition of the death penalty on individuals with severe mental illness.

1. Task Force on Mental Disability and the Death Penalty

After the *Atkins v. Virginia* decision holding that the execution of people with mental retardation violates the Eighth Amendment's ban on cruel and unusual punishment, the Individual Rights and Responsibilities Section of the America Bar Association ("ABA") determined it was necessary to "consider the extent, if any, to which other types of impaired mental conditions ought to lead to exemption from the death penalty."[79] To this end, the ABA formed an interdisciplinary "Task Force on Mental Disability and the Death Penalty," composed of 24 lawyers and mental health professionals (both practitioners and academics), including representatives from mental-health advocacy organizations.[80]

After two years of deliberations, the task force drafted a policy stating that the following groups of people should be excluded from capital punishment: 1) "Offenders who have persistent mental illness or mental

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[78] *Atkins v. Virginia*, 536 U.S. 304, 316 n.21 (2002) (citing to *Thompson v. Oklahoma*, 487 U.S. 815, 830, 831 (1988) (considering the views of "respected professional organizations, by other nations that share our Anglo-American heritage, and by the leading members of the Western European community")).

[79] A.B.A., Report of the Task Force on Mental Disability and the Death Penalty, 1, https://www.apa.org/pubs/info/reports/mental-disability-and-death-penalty.pdf.

[80] *See id.* Among the mental-health advocacy organizations included in the ABA's task force were the American Psychological Association, the American Psychiatric Association, and the National Association for the Mentally Ill. *See id.*

retardation that began before the offense ..."; 2) "defendants who, at the time of the offense, had a severe mental disorder..."; and 3) "offenders who, once convicted and sentenced, become incompetent to be executed because of a mental disorder."[81]

In 2006, the American Psychological Association and American Psychiatric Association[82] both adopted policies incorporating the language proposed by the task force. The task force's recommendations also formed the basis for ABA Resolution 122A, passed in 2006. The resolution holds that defendants should not be executed or sentenced to death if, at the time of the offense, they had "significant limitations in both their intellectual functioning and adaptive behavior," or had "a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law."[83]

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[81] *See* Am. Psychological Ass'n, *Associations concur on mental disability and death penalty policy* (January 2007) 38 Monitor on Psych. 1, *available at* http://www.apa.org/monitor/jan07/associations.aspx (last visited Oct. 25, 2016).

[82] In 2014, the American Psychiatric Association reaffirmed its long-standing position statement endorsing a moratorium on capital punishment in the United States, based on the "weaknesses and deficiencies of the current capital sentencing process including considerations in regard to the mentally ill and developmentally disabled." *See* Am. Psychiatric Ass'n, *Position Statement on Moratorium on Capital Punishment in the United States*, *available at* https://www.psychiatry.org/File%20Library/Learn/Archives/Position-2014-Moratorium-Capital-Punishment.pdf (last visited Oct. 25, 2016).

[83] A.B.A., Mental Illness Resolution (2006), *available at* http://www.americanbar.org/groups/committees/death_penalty_representation/resources/dp-policy/mental-illness-2006.html (last visited Oct. 25, 2016).

The ABA's resolution would also exempt those whose onset of mental illness occurs after sentencing.[84] Indeed, mental health conditions should be taken into account during all phases of a capital case, including the execution itself. The execution of individuals suffering from severe mental illness has no retributive or deterrence value. In *Ford v. Wainwright*, the Supreme Court held that that no legitimate government purpose is served by the execution of someone who is not competent at the time of their execution, stating:

> The reasons at common law for not condoning the execution of the insane -- that such an execution has questionable retributive value, presents no example to others, and thus has no deterrence value, and simply offends humanity -- have no less logical, moral, and practical force at present. Whether the aim is to protect the condemned from fear and pain without comfort of understanding, or to protect the dignity of society itself from the barbarity of exacting mindless vengeance, the restriction finds enforcement in the Eighth Amendment.[85]

This reasoning equally applies to capital cases wherein the offender is suffering from a severe mental illness and, as demonstrated, does not have the mental and intellectual capacity to understand or appreciate the circumstances of his actions.

2. *Amicus Curiae* MHA

Since 2006, *amicus curiae* MHA has called for a complete moratorium on the use of the death penalty.[86] MHA bases this position, in

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[84] *See id.*

[85] *Ford v. Wainwright* (1986) 477 U.S. 399, 399-400.

[86] *See* Mental Health America, *Position Statement 54: Death Penalty and People with Mental Illnesses*, 1, *available at*
(Continued...)

part, on the heightened risk of the discriminatory application of the death penalty facing people with mental illness.[87] For reasons discussed in this brief, MHA posits that "federal and state governments [should] not ... threaten or use the death penalty for any accused who suffered from mental illness at the time of the crime, trial, sentencing, or execution."[88]

VI. CONCLUSION

Individuals with severe mental illness, as citizens of the State of California, as citizens of the United States of America, and as human beings, have a right to due process of the law and freedom from cruel and unusual punishment. If this Court continues to impose the death penalty upon individuals who suffer from severe mental illness—individuals like Mr. Steskal—then it will be affirming the infliction of cruel and unusual punishment upon this vulnerable class of individuals.

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http://www.mentalhealthamerica.net/positions/death-penalty (last visited Oct. 25, 2016).

[87] *See id.* The disadvantages faced by people with mental illness when navigating the criminal justice system are discussed in Section III *supra*.

[88] *Id.*

For the reasons stated above, MHA and NAMI urge the Court to bar the imposition of the death penalty on individuals with severe mental illness and protect its citizens—*all* of its citizens—from such an unjust result.

Dated: October 28, 2016

Respectfully submitted,

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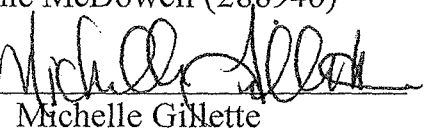
By: 
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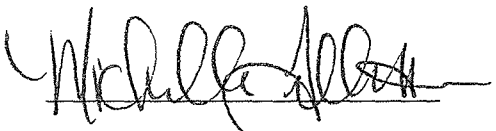
CERTIFICATE OF WORD COUNT

Pursuant to Rule of Court rules 8.520(c) and 8.630, I certify that this Brief of *Amici Curiae* Mental Health America and National Alliance on Mental Illness in Support of Defendant/Petitioner Maurice K. Steskal contains **9,777** words, not including the Table of Contents, Table of Authorities, this Certificate, the caption page, signature blocks, or attachments.

Dated: October 28, 2016

Respectfully submitted,

By: 

Michelle Gillette

DECLARATION OF SERVICE

I, Carol E. Romo, state:

My business address is 275 Battery Street, 23rd Floor, San Francisco, California 94111. I am over the age of eighteen years and not a party to this action.

On the date set forth below, I served the foregoing document described as:

MENTAL HEALTH AMERICA AND NATIONAL ALLIANCE ON MENTAL ILLNESS' APPLICATION FOR LEAVE TO FILE AN AMICI CURIAE BRIEF IN SUPPORT OF DEFENDANT AND APPELLANT MAURICE G. STESKAL

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I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct.

Executed on October 28, 2016, at San Francisco, California.

Carol E. Romo