Saint Louis University Public Law Review

Volume 25
Number 2 *Mental Capacity and the Death Penalty (Volume XXV, No. 2)*

Article 8

2006

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CAPITAL PUNISHMENT AND MENTAL HEALTH ISSUES: GLOBAL EXAMPLES

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I. INTRODUCTION

When we were first invited to contribute to this special edition of the journal we felt fairly confident that we could bring to the United States of America's debate a flavour of the issues relating to mental illness, mental impairment, and medical practitioner involvement gleaned from amongst the countries where the Centre for Capital Punishment Studies ("CCPS") is privileged to have worked. The most recent summary of the CCPS' country work is available through our website.[1] One of the objectives of the work of the CCPS is to broaden the scope and the geography of capital punishment scholarship in an attempt to redress the imbalance caused by the dominance of the data provided by scholars and activists in the U.S. which invariably only addresses the issue of capital punishment in that country. The data originating from the U.S. is reliable, accessible, and current, unlike that available from many other retentionist countries, and it is therefore understandable that scholars and students have focused on the death penalty debate in this region. However, we have come to realise that it is unhelpful to simply extrapolate from the experience of the U.S. to explain the death penalty in other cultures and jurisdictions.

Our confidence in getting this data has been somewhat misplaced as regrettably, though in hindsight predictably, we have been frustrated in most of

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1. Centre for Capital Punishment Studies, *Summary of International Activities, available at* http://www.wmin.ac.U.K./law/docs/CCPS%20Int%20Activities%20paper%20June%202005.doc [hereinafter CCPS].

our enquiries because of the paucity of accessible data, which in some cases is due to its absence and in others because it has not been made available to us. Whilst our enquiries have not benefited this paper, our requests will have stimulated some to address this issue with more importance thereby leading, one hopes, to improved practice.

Therefore, our research on this issue is a "work in progress" and necessarily some of our observations need to be seen in that context. What we do know is that there is a general lack of knowledge and understanding as to the role of mental health issues amongst medical, legal, and criminal justice personnel in many of the countries with which we work, and that a dialogue needs to be developed between the key personnel, as well as protocols to address the paucity of knowledge and resources. This paper will begin by discussing the role of physicians and psychiatrists in the context of the country information we have available, addressing the practical and ethical implications for both practitioners and those capital defendants with mental health issues. It will conclude by discussing the protocol the CCPS has developed (the Humane Advocacy Programme) and is piloting with some success in Jamaica, which seeks to address some of the causes and consequences of problems arising from this issue.

II. CULTURAL ASPECTS OF PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT

The cultural context in which capital cases occur must be taken into account when examining the ethical implications of forensic psychiatry. For example in the Arab context, it has been argued that societal and family structures often differ from those in Western countries, and that this indirectly impacts on issues such as the doctor-patient relationship.[2] Additionally, traditional beliefs and healing may exist alongside more modern medical systems, often successfully.[3] Clearly such factors must be very relevant when looking at non-Western frameworks of psychiatry and ethics.

Issues of mental illness, mental impairment, and physician involvement in the capital punishment process have recently come to the forefront in Papua New Guinea ("PNG"), which has not carried out an execution since 1954 when the country was the subject of colonial rule by near neighbour Australia.[4]

2. Ahmed Okasha, *The Impact of Arab Culture on Psychiatric Ethics, in* ETHICS, CULTURE, AND PSYCHIATRY: INTERNATIONAL PERSPECTIVES 15, 18-20 & tbl. 2-1 (Ahmed Okasha, Julio Arboleda-Florez & Norman Sartorius eds., 2000).

3. *Id.* at 20.

4. Amnesty Int'l, *Papua New Guinea: The State as Killer*?, at 2, ASA 34/001/2004 (2004), *available at* http://web.amnesty.org/library/pdf/ASA340012004ENGLISH/$File/ASA3400104.pdf. [hereinafter State as Killer].

PNG gained independence in 1975[5] and restored the death penalty in 1991, since when, only a handful of death sentences have been passed.[6] PNG provides a very strong example of how important it is in any country work to grasp fully the complex socio-cultural and socio-legal background before developing any penal policy strategies. The discipline that most adequately assists in the understanding of this complex society is anthropology without which we believe it is nigh impossible to formulate any national policy that would have the acceptance of the population. PNG has a population of approximately five million persons comprising some 800 different languages,[7] all of which have deeply rooted traditions of greater influence on its members than national policies, including medical issues.[8]

An illustration of the power of traditional beliefs is provided by the trial of Mr. Siviri who had been convicted of "one of the worst cases of wilful murder" of a woman, Komano Paul. The convicting judge said he "would have imposed the death penalty were it not for the people's belief in sorcery."[9] Justice Elenas Batari went on to say, "The prisoner believed the death of his wife resulted directly from sorcery. It is the existence of this sorcery factor that will save the prisoner from the death sentence. It is a mitigation factor that I must take into account."[10] A strongly worded op-ed piece the following day in the same paper condemned the judgement, arguing:

> The mounting count of disgusting murders in the name of rooting-out sorcery must stop.[11] Our country's image is reduced to that of a medieval fiefdom, where superstition ruled, supposed witches were burned alive, and innocent people were publicly drowned.[12]

PNG has and continues in independence to benefit from the "developed" medical practices of the West, through its relationship with Australia and its

5. Australia's Prime Ministers, Timeline, http://primeministers.naa.gov.au/timeline.asp?action=show&viewAll=true (last visited Apr. 19, 2006).

6. State as Killer, *supra* note 4, at 2.

7. David Klaus, *The Use of Indigenous Languages in Early Basic Education in Papua New Guinea: A Model for Elsewhere?* 1, http://www.sil.org/asia/ldc/ parallel_papers/david_klaus.pdf (last visited Apr. 19, 2006) (citing The Ethnologue: Languages of the World, SIL Inc., http://www.ethnologue.com/show_country.asp?name=Papua+New+Guinea).

8. Derek Woolner, *Papua New Guinea: 20 Years On* 1-2 (Parliamentary Research Service, Research Paper No. 4, 1995), *available at* http://www.aph.gov.au/library/pubs/RP/1995-96/96rp04.pdf.

9. Frank Senge Kolma, *Belief in Sorcery Saves Man from Gallows*, THE NATIONAL, Sept. 2, 2004, *available at* http://66.249.93.104/search?q=cache:CDcs7jPWhpgJ:www.thenational.com.pg/0902.

10. *Id.*

11. Editorial, *Sorcery, the Cruelest Perversion*, THE NATIONAL, Sept. 3, 2004, *re-posted at* http://www.network54.com/Forum/154461/thread/1098176369/last-Sorcery+%E2%80%93+the+cruelest+perversion.

12. *Id.*

connections and adherence to the guidance of the Australia and New Zealand Medical Associations. However one has to be cautious of the inevitable and perhaps growing influence of the traditional tribal approaches.

Paradoxically, the increasing influence of traditional and tribal measures in responding to criminal problems has in some respects slowed the march towards the resumption of executions. The traditional principle of Wantok[13] combines some largely positive and enviable measures, such as restorative justice and alternative dispute resolution at one end of the continuum,[14] with less positive processes at the other end such as "life for life" or "payback."[15] The highest incidence of murders takes place in a tribal context, but these rarely attract the "wilful" dimension needed to satisfy capital murder.[16] The restricting influence of Wantok could occur at the arrest, prosecution, sentence, and implementation stages of the death penalty, and comes about because if members of one tribe participate in the capital process they leave themselves open to retaliation by the tribe of the accused.[17]

Not only has PNG not had an execution since 1954, but they do not have an execution chamber.[18] In 2005, having visited Texas and been informed by its Execution Protocol, the PNG Cabinet finally decided on lethal injection as its mode of execution, but still lacks the appropriate facility and personnel to implement the practice.[19] The few death sentences passed since restoration in 1991, could reflect a very thoughtful and measured interpretation of which capital murder convictions warrant a death sentence. Alternatively, it could be that the power of Wantok is inhibiting those sentences; an effect that could potentially inhibit the passing and implementation of death sentences for some time yet.[20] The medical profession therefore, has some time to formulate an

13. Literally meaning "one language" and denoting a kinship system that, extends beyond an individual's family, clan, and tribal group to other families, clans, and tribes in their respective districts. Loyalty to the Wantok has been described as the "fundamental intrinsic human value that Papua New Guineans possess." Garry Sali, *Papua New Guinea*: *Law Passed Without Debate*, THE NATIONAL, Oct. 20, 2003, *available at* http://venus.soci.niu.edu/~archives/ABOLISH/feb04/1174.html.

14. Noel Sarei, *Country Report: Papua New Guinea*, 142, 145-46 (123d Int'l Senior Seminar, Participants' Papers, Resource Material Series No. 63).

15. Nick Squires, *Deadly Twist to PNG's Tribal Feuds*, BBC NEWS, Aug. 25, 2005, *available at* http://news.bbc.co.UK/1/hi/programmes/from_our_own_correspondent/4181042.stm . *See also* Sali, *supra* note 13.

16. *See* Kolma, *supra* note 9 (discussing the willful nature of a murder as the trigger for the imposition of capital punishment).

17. *See* Sali, *supra* note 13.

18. *See* State as Killer, *supra* note 4, at 2-4.

19. *See Minister May Push for Death by Lethal Injection*, PAPUA NEW GUINEA POST-COURIER, Jan. 18, 2005, at 4, *available at* LEXIS, News & Business, Combined Sources, News All; CCPS, *supra* note 1, at 12-13.

20. Sali, *supra* note 13.

ethical response to the call for their involvement at any stage of the capital process.

III. RESTRICTIONS ON THE PARTICIPATION OF HEALTH PRACTITIONERS

What follows is a collection of information relating to the limitations and obligations on the involvement of medical practitioners, a definition which must go beyond medical doctors to close off the participation of the paramedical professionals. Nurses and others peripheral to medical treatments must also be prevented from participating in the industry of capital punishment, and it is as important to protect them from being coerced to participate.

International standards prohibit the use of the death penalty against "persons who have become insane,"[21] and recommend that it not be used against people of "extremely limited mental competence, whether at the stage of sentence or execution."[22] Schabas[23] provides clarity to this debate from the perspective of customary international law, which complements the position of the United Nations and its guidelines.[24] A key ruling in the U.S. was the decision of the U.S. Supreme Court in *Ford v. Wainwright*,[25] in which the Court ruled that it is unconstitutional to execute insane prisoners. By 1989, national medical associations, in at least nineteen countries, had formally stated their opposition to physician "participation" in capital punishment.[26] The table that follows was formulated by psychiatrist Dr. Robert Ferris and Dr. James Welsh of Amnesty International.[27]

21. U.N. Econ. & Soc. Council, Crime Preventions & Criminal Justice, Report on the capital punishment and implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty, ¶ 62, U.N. Doc. E/1995/78 (June 8, 1995), available at http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/f8578a24e738bcd5802566c00041b9d8?Opendocument [hereinafter Implementation of the Safeguards].

22. *See* Implementation of the Safeguards, *supra* note 21, at Annex II(d).

23. *See generally* WILLIAM A. SCHABAS, THE ABOLITION OF THE DEATH PENALTY IN INTERNATIONAL LAW (2d ed. 1997); William A. Schabas, *International Norms on Execution of the Insane and the Mentally Retarded*, 4 CRIM. L. F. 95 (1993).

24. *See generally* Implementation of the Safeguards, *supra* note 21. International standards prohibit the use of the death penalty against "persons who have become insane." *Id.* at ¶ 61. International standards also recommend that it not be used against people of "extremely limited mental competence, whether at the stage of sentence or execution." *Id.* at Annex II(d).

25. Ford v. Wainwright, 477 U.S. 399, 409-10 (1986).

26. Amnesty Int'l, *Health Professionals and the Death Penalty Act*, ACT 50/003/1989.

27. Robert Ferris & James Welsh, *Doctors and the Death Penalty: Ethics and a Cruel Punishment*, *in* CAPITAL PUNISHMENT: STRATEGIES FOR ABOLITION 63, 79 tbl. 3.2 (Peter Hodgkinson & William A. Schabas eds., 2004).

Elements of death penalty policy of selected professional associations	
Association	Policy
International bodies	
World Medical Association	It is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process. (Resolution on physician participation in capital punishment, 2000, revising 1981 resolution)
World Psychiatric Association	A psychiatrist [should never] participate in legally authorised executions nor participate in assessments of competency to be executed (Declaration of Madrid, 1996)
International Council of Nurses	Opposes nurses' participation; calls on national nurses' associations to work for abolition (1989, restated 1998 as ADD)[28]
Selected national organisations	
American Medical Association	Opposes all medical participation except certifying death
American Psychiatric Association	Calls for moratorium (2000)
American Nurses Association	Opposes nurses' participation (1984)
American Public Health Association	Health personnel "should not be required nor expected to assist in legally authorised executions" (1985); calls for abolition (1986); reiterates opposition to health professional participation in executions (1994, 2000)

28. INT'L COUNCIL OF NURSES, POSITION STATEMENT: TORTURE, DEATH PENALTY AND PARTICIPATION BY NURSES IN EXECUTIONS (1998), *available at* http://www.icn.ch/pstorture.htm (this statement replaces INT'L COUNCIL OF NURSES, POSITION STATEMENT: DEATH PENALTY AND PARTICIPATION BY NURSES IN EXECUTIONS (1989)).

British Medical Association	Opposes the death penalty worldwide (2001)
Guatemala Medical Association	Opposes medical participation in judicial execution (1997)
Philippines Medical Association	Opposes medical participation in judicial execution (1997)
Nordic Medical Associations	Oppose all participation by doctors in the death penalty (1986)
Royal College of Psychiatrists	Resolution concerning the participation of psychiatrists (1992)[29]

In a 1995 judgment in India, a two-judge bench of the Supreme Court ruled that the practice of keeping the body of the condemned prisoner hanging for half an hour was inhumane.[30] It stipulated that a convict shall remain hanging only until he is declared dead by the medical officer.[31] In its attempt to highlight the inhumane element of leaving a person hanging, the Supreme Court ruling meant that doctors would have to be involved much more actively in the application of the death penalty. In order to meet the requirement laid down by the court, doctors would need to check the body of a dying inmate every few minutes. Questions arise as to what the doctor should do if he or she finds the condemned still alive. Should he or she attempt to save the life of the condemned in accordance with the Hippocratic Oath, undertaken by all Indian

29. *Resolution Concerning the Participation of Psychiatrists in Executions*, 16 PSYCHIATRIC BULL. 457, 457 (1992). *See also Capital Punishment and the Medical Profession*, 18 PSYCHIATRIC BULL. 250-51 (1994) (provides a broader statement on the subject). "Under no circumstances should a psychiatrist participate in legally authorised executions nor participate in assessments of competency to be executed." *Id.*

30. Amar Jesani, *Medicalisation of 'Legal' Killing: Doctors' Participation in the Death Penalty*, INDIAN J. OF MED. ETHICS, Oct.-Dec. 2004, *available at* http://www.issuesinmedicalethics.org/124ed104.html.

31. *Id.*

physicians, or should the doctor instruct the hangman to carry on with the procedure in accordance with the India Supreme Court's ruling?[32]

Although the Indian Medical Association is a member of the World Medical Association which strongly opposes medical participation in the death penalty, it has not actively undertaken any action to oppose the death penalty in India.[33] It has also failed to respond to the 1995 judgement requiring the medical officer to participate in the execution.[34]

In 2003, the Law Commission of India recommended lethal injection as an alternative method of execution.[35] The recommendation poses further ethical challenges on the medical profession, as it is likely that "physicians, nurses or medical technicians will have to initiate, monitor and participate actively in the process of execution.[36] This would also involve the selection of sites for intravenous access and placement of intravenous lines."[37]

IV. PSYCHIATRY AND CAPITAL PUNISHMENT

An all-encompassing definition of mental illness that has universal application is difficult to provide. According to the Mental Health Foundation, a United Kingdom ("U.K.") based charity, mental health problems cover:

> A very wide spectrum, from the worries and grief we all experience as part of everyday life, to the most bleak, suicidal depression or complete loss of touch with everyday reality. . . . When someone experiences severe and or enduring mental health problems they are sometimes described as "mentally ill."[38]

In the U.S., the American Psychiatric Association defines severe mental illness as:

> The presence of a severe psychiatric disorder (including schizophrenia, schizoaffective disorder, major depression, and bipolar disorder) accompanied by significant functional impairment, disruption of normal life tasks, periods of hospitalization, and need for psychotropic medication.[39] People with severe mental illness are a heterogeneous group in which cultural, social, economic,

32. *Id.*

33. Anant Bhan, *Killing for the State: Death Penalty and the medical profession. A call for action in India*, vol. 18, no. 4 NAT'L MED. J. OF INDIA 205, 205-08 (2005).

34. *Id.*

35. Law Commission of India, 187th Report on Mode of Execution of Death Sentence and Incidental Matters, October 17, 2003, DO No.6 (3)/85/2003-LC (LS), *available at* http://lawcommissionofindia.nic.in/reports/187th%20report.pdf. *See also* Bhan, *supra* note 33, at 206.

36. Bhan, *supra* note 33, at 206.

37. *Id.*

38. Mental Health Found., Mental Health Problems, http://mentalhealth.org.uk/page.cfm?pagecode=PMMH (last visited Apr. 9, 2006).

39. American Psychiatric Association, A Definition of Severe Mental Illness, http://www.psych.org/aids/modules/illness/sld005.htm (last visited Apr. 9, 2006).

> ethnic, and geographic factors may play important roles in sexual and drug use risk behaviours and the ability to implement safer practices.[40]

According to the American Civil Liberties Union, the most common illnesses experienced by death row inmates include: Bipolar Disorder, Borderline Personality Disorder, Post-Traumatic Stress Disorder, Schizoaffective Disorder, Schizophrenia, Depression, Recurrent Thoughts of Death, or Suicide.[41]

Although 122 countries have abolished the death penalty to date, seventy-four countries retain it either in law or practice.[42] Perhaps a more telling statistic is that approximately eighty-six percent of the world's population live in countries that continue to provide for capital punishment in their laws though many could be classified as de facto abolitionists.[43] Its use, however, has been gradually restricted over time; most countries subscribe to domestic or international obligations, which meet safeguards not to execute juveniles, pregnant women or new mothers, and the elderly.[44] Those that suffer from forms of mental disorder are also exempt from execution in many countries.[45] In the U.S., for example, the Supreme Court in *Ford v. Wainwright*[46] banned the execution of the insane ruling that it is cruel and unusual punishment and violates the Eighth Amendment's protection. An Afghan Court recently asserted its intention to look into the mental state of a man currently on trial for converting to Christianity, a crime punishable by death under Islamic law.[47] He has now been discharged from court under the guise of "suffering" from some mental illness.[48] One suspects that this outcome has been arrived at to

40. *Id.*

41. American Civil Liberties Union, Mental Illness and the Death Penalty in the United States, http://www.aclu.org/capital/mentalillness/10617pub20050131.html (last visited Apr. 7, 2006).

42. Amnesty Int'l, Facts and Figures on the Death Penalty, http://web.amnesty.org/pages/deathpenalty-facts-eng (last visited Apr. 7, 2006).

43. *See id.*

44. *See* Death Penalty Information Center, History of the Death Penalty, Pt. II: Limiting the Death Penalty, http://www.deathpenaltyinfo.org/ article.php?scid=15&did=411 (last visited Apr. 7, 2006).

45. American Civil Liberties Union, *supra* note 41.

46. Ford v. Wainwright, 477 U.S. 399, 409-10 (1986).

47. Jody Brown, *Afghan Convert to Christianity 'Could Be Mad,' Says Prosecutor*, AGAPE PRESS, Mar. 22, 2006, *available at* http://headlines.agapepress.org/ archive/3/222006a.asp.

48. Jody Brown & Allie Martin, *Afghan Court Releases Christian Convert for 'Lack of Information'*, AGAPE PRESS, Mar. 27, 2006, *available at* http://headlines.agapepress.org/archive/3/272006a.asp.

avoid further international clamour. He remains at risk of extra-judicial killing.[49]

Greater recognition of mental disorders and international trends limiting the use of capital punishment has brought psychiatry to the forefront in the application of the death penalty. Psychiatrists are becoming increasingly involved in the following stages of a case:

- Evaluation and testimony bearing on a defendant's capacity to stand trial;
- Treatment to restore or maintain a defendant's competency to stand trial;
- Evaluation and testimony bearing on a defendant's criminal responsibility;
- Evaluation and testimony at the sentencing stage;
- Evaluation and testimony bearing on a defendant's capacity to waive appeals;
- Evaluation and testimony bearing on a defendant's competency to be executed;
- Treatment to restore a defendant's competency to be executed; and
- Treatment of symptoms not relevant to the defendant's legal situation.[50]

The inclusion of psychiatrists as expert witnesses in capital cases is intended to help ensure that the death penalty is not applied to the mentally ill;[51] the reasoning being that those suffering from mental illness are not culpable for their actions and as such it would be cruel and unjust to execute them.[52] Furthermore, some suggest that there is no deterrent effect in executing the mentally ill since the accused (and more importantly any persons in the community experiencing severe mental illness) are incapable of understanding the implications of a death sentence.[53] The U.S. Supreme Court has recognised this in its judgment banning the execution of the mentally retarded.[54]

Following on from our comments about lack of data on the issue of mental illness/mental impairment and the participation of medical practitioners in the capital punishment process we can draw some information from a study conducted by Ferris and Welch in 1995.[55] They surveyed psychiatric associations and practitioners in fifty-five countries of which twenty-three

49. Jody Brown & Allie Martin, *Group Says Rahman One of Thousands Awaiting Death Sentence for Accepting Christ*, AGAPE PRESS, Mar. 28, 2006, *available at* http://headlines.agapepress.org/archive/3/282006c.asp.

50. Ferris & Welsh, *supra* note 27, at 70.

51. *Id.* at 69 (citing G. Hazard & D. Louisell, *Death, and State, and the Insane: Stay of Execution*, 9 UCLA L. REV. 381 (1962)).

52. American Civil Liberties Union, *supra* note 41.

53. *See* Atkins v. Virginia, 536 U.S. 304, 319-20 (2002).

54. *Id.* at 321.

55. Ferris & Welsh, *supra* note 27, at 88.

replied.[56] The purpose of the survey was to identify the nature and number of psychiatric services available to those subject to capital punishment; only two reported that no psychiatric services had been available to capital defendants at any stage.[57] They go on to say:

> Most countries reported that psychiatrists only "sometimes" examined defendants; most commonly, this was before sentencing and least commonly after arrest. A smaller number indicated that defendants were "mostly or always" examined at the various stages of proceedings. The defendant's mental state at the time of the crime was reported as the most frequent focus of psychiatric testimony, followed by determination of criminal responsibility and then predictions of future dangerousness.
>
> Concerning the ethically contentious questions of psychiatric assessment of mental competence to be executed and treatment to restore competence, replies from several countries suggested that in a small number of cases, not only were assessments of competency carried out but treatment to restore competence given, in some cases involuntarily.
>
> Although the questionnaire did not include a direct enquiry concerning the link between an assessment of mental incompetence, treatment to restore competence, and any decision to commute the death penalty to life imprisonment, the replies given suggested that in four of the responding countries the incompetent were not treated and did not have their sentences commuted. This suggests that execution of defendants known to be mentally incompetent had taken place. For five other countries, replies suggested that defendants deemed mentally incompetent were sometimes treated (to restore competence) but did not always have their sentences commuted. This suggests that defendants were being executed in some cases after having their mental competence restored by psychiatric treatment.
>
> Although 80 percent of respondent countries had a psychiatric association the number of psychiatrists in each country varied enormously from one (two countries) to twelve thousand. More than 80 percent of respondents reported little or no active discussion on capital punishment in their country and a similar proportion reported the absence of any declared position or the issuing of ethical guidelines on the part of their national psychiatric association.
>
> Only four countries affirmed any law or policy excusing psychiatrists on grounds of conscience from assessment or treatment of defendants, which could facilitate an execution.
>
> The modest return rate means that the survey cannot claim to be representative of countries retaining the death penalty. By its nature, and considering the methodological limitations, only basic information has been gathered.

56. *Id.*
57. *Id.*

> However, a picture emerges of psychiatric personnel shortages in a significant number of countries, depriving defendants in capital cases and death row inmates of assessment and treatment, of the ethically contentious practice of assessment of competence to be executed and treatment to restore competence (in a small number of countries) and of a major dearth of ethical discussion or corporate guidance from professional associations in the great majority of retentionist countries. There is clearly cause for concern and a need for more detailed information.[58]

In the Philippines, despite provisions in the law that recognise mental disorder as an issue that needs to be addressed before charges are brought against a defendant,[59] the application of these rules in court is inconsistent. In the case of Marlon Parazo,[60] a mentally impaired, deaf, and mute man with a mental age of eight, the Supreme Court upheld the Regional Trial Court's sentence of death for rape and attempted murder. At no stage of the proceedings, including on appeal to the Supreme Court, were Marlon's mental and physical disabilities taken into account.[61] It was only after action by a local anti-death penalty group[62] that the Supreme Court ordered a review and full medical examination. The Court, accepting that he could not understand the charges against him nor assist in his own defence, ordered a retrial with the assistance of counsel and a competent sign language expert.[63]

In the case of Arnel Alcalde,[64] where the defendant was charged with two counts of parricide (a crime which could attract a death sentence), the Regional Trial Court refused to order a medical examination, despite the submission by the defence of a report stating that the accused had been confined to a psychiatric ward several times over the last few years for bipolar mood disorder. In this case, however, the Supreme Court overruled the trial court's

58. *Id.* at 88-89.

59. The Philippine Criminal Code provides:

> SEC. 11. *Suspension of arraignment.* – Upon motion by the proper party, the arraignment shall be suspended in the following cases:
>
> (a) The accused appears to be suffering from an unsound mental condition which effectively renders him unable to fully understand the charge against him and to plead intelligently thereto. In such case, the court shall order his mental examination and, if necessary, his confinement for such purpose.

REV. R. CRIM. P. 116.11(a), *in* RUBEN E. AGPALO, HANDBOOK ON CRIMINAL PROCEDURE 355 (2001) (Phil.).

60. People v. Parazo, G.R. No. 121176 (July 8, 1999) (Phil.), *available at* http://www.supremecourt.gov.ph/jurisprudence/1999/jul99/121176.htm.

61. Amnesty Int'l, *Phillipines: Marlon Parazo, Deaf and Mute, Faces Execution*, at 1, ASA 35/07/98, *available at* http://web.amnesty.org/library/pdf/ASA350071998ENGLISH/$File/ASA3500798.pdf [hereinafter *Phillipines: Marlon Parazo*].

62. *Parazo*, G.R. No. 121176 (Phil.); *Phillipines: Marlon Parazo*, *supra* note 61.

63. *Supra* note 62.

64. People v. Alcalde y Pascasio, G.R. Nos. 139225-28 (May 29, 2002) (Phil.), *available at* http://www.supremecourt.gov.ph/jurisprudence/2002/may2002/ 139225_28.htm.

decision asserting that, "If it be found that by reason of such affliction the accused could not, with the aid of counsel, make a proper defence, it is the duty of the court to suspend the proceedings and commit the accused to a proper place of detention until his faculties are recovered." [65]

A legal precedent was established in the case of Marivic Genosa[66] who was sentenced to death after killing her abusive husband whilst he was in a drunken sleep. The Supreme Court, recognising for the first time "battered woman's syndrome," ruled that the case should be returned to the regional trial court, and recommended that the court consult clinical psychologists to assess the defendant's state of mind at the time of the killing.[67]

V. ETHICAL ISSUES AND THE RELATIONSHIP BETWEEN LAW AND PSYCHIATRY IN CAPITAL CASES

The question of the ethical dilemmas raised by the involvement of psychiatrists at these various stages of the process has been discussed from a number of viewpoints. Eastman and McInerny argue that one way of ethically defining a doctor's involvement in capital punishment is according to proximity to the execution itself.[68] Thus they set out seven chronological stages of participation leading up to the execution, "conceived of in terms of *degrees of remoteness*, including the degree of indirect or direct involvement to the actual procedure of execution."[69] These stages of participation start with the investigation stage of a capital trial, and move through involvement in assessing fitness for trial, testifying at the trial and sentencing, assessment and treatment for execution, and finally execution itself and certification of death.[70]

Forensic psychiatry has become an integral part of capital cases in the U.S. and can play a crucial role in determining how an offender is dealt with. Forensic psychiatrists deal with all the issues mentioned above, as well as treatment and security issues for offenders suffering from mental disorders. Nigel Eastman has analysed the ethical issues arising in forensic psychiatry in relation to the fact that it is an interface discipline where two very different disciplines, law and psychiatry, meet.[71] He describes it in terms of two very different lands, "Legaland" and "Mentaland" which "have very different

65. *Id.*

66. People v. Genosa, G.R. No. 135981 (Jan. 15, 2004) (Phil.), *available at* http://www.supremecourt.gov.ph/jurisprudence/2004/jan2004/135981.htm.

67. *Id.*

68. Nigel Eastman & Tim McInerny, *Psychiatrists and The Death Penalty: Ethical Principles and Analogies*, vol. 8, no. 3 J. OF FORENSIC PSYCHIATRY 487, 583-601 (1997).

69. *Id*. at 586.

70. *Id*.

71. Nigel Eastman, *Psycho-legal Studies as an Interface Discipline*, *in* BEHAVIOUR, CRIME AND LEGAL PROCESSES: A GUIDE FOR FORENSIC PRACTITIONERS 83 (James McGuire et al. eds., 2000).

histories, cultures and, perhaps most obviously, their inhabitants speak different languages."[72] They also "pursue different life purposes by different means of thinking and behaving"[73] which means they usually have little contact. This means that when they do meet or have need of each others' skills a kind of "cognitive dissonance"[74] occurs, as they try to understand each other and the new context in which they find themselves.

In addition, those in the legal discipline attempt to ensure that the concepts of those in the mental health disciplines are forced into a legal model. In practice, this leads to a variety of conflicts within the forensic context, including the use of medical concepts and terminology in a legal setting, which distorts the medical meaning to fit its own legal constructs. An example of this in the capital punishment field is the use of the concept of insanity, which appears to be a legal construct bearing little relation to medical concepts of mental disorder. Roger Hood makes the interesting point that although all retentionist countries have some provisions exempting the insane from execution, this does not indicate to what extent the insane or mentally disturbed are in reality exempted from execution.[75] In other words, mental disorder can fall short of the requirements of insanity under the law.

Apart from the overriding conceptual difficulties and conflicts caused when law and psychiatry meet, further ethical difficulties arise in specific forensic contexts. These are exacerbated in capital cases where the outcome may clearly be grave. Applebaum has argued that the ethical position of a psychiatrist may be different when they are acting outside the realms of their profession.[76] So this type of "situational ethics" argues that the application of forensic psychiatry, for example, by testifying on such matters in a courtroom, is quite different from the practice of psychiatry and treatment of patients, and therefore a different ethical analysis may be required.[77] Others, such as Stone, argue that the problem with this analysis is that whilst doctors are governed by medical ethics, in the legal arena the principle of "truthfulness" is key.[78] However lack of scientific consensus means that it is difficult for experts to testify as to the objective "truth" of issues such as future dangerousness, and Stone argues that those testifying on such matters should reveal to the court the

72. *Id*.

73. *Id*.

74. *Id*.

75. ROGER HOOD, THE DEATH PENALTY: A WORLDWIDE PERSPECTIVE 17 (3d ed., Oxford University Press 2002) (discussing M. ANCEL, THE DEATH PENALTY IN EUROPEAN COUNTRIES (1962) and Morris Reports (1967)).

76. *See* Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J. L. AND PSYCHIATRY 249, 251-52 (1990).

77. *Id.* at 252.

78. *See* Alan A. Stone, *Revisiting the Parable: Truth without Consequences*, 17 INT'L J. L. PSYCHIATRY 79, 83-88 (1994).

limitations of the claims they are making.[79] So, for example, he examines the testimony of Dr. James Grigson, dubbed "Dr. Death" by the U.S. media for his role in sending a large number of offenders to death row.[80] Dr. Grigson was castigated by the American Psychiatric Association for testifying as to the likely risk of the future dangerousness of virtually all of these offenders, sometimes without examining them, and in a manner that persuaded the court as to the objective "truth" of his claim.[81] This illustrates the problematic nature of attempts to shoehorn complex medical concepts and testimony into objective legal standards of "truth." Once again this demonstrates some of the complex ethical issues raised by the disjunction between the two disciplines of law and psychiatry, when they meet in the form of forensic psychiatry.

Can the problems caused by this interface be resolved? Eastman has argued that it is possible to minimize the disjunction caused when law and psychiatry are "drawn into an apparently common purpose"[82] in the form of forensic psychiatry, by "encouraging legal rules which put the two disciplines into inherently 'least disjunctive' model interactions."[83] One solution would of course be to remove the participation of doctors from the forensic process altogether; arguably, however, this is neither feasible nor desirable, since as the American Medical Association has stated, doctors have a civic as well as medical duty "to assist in the administration of justice and in ensuring that individuals are treated fairly and punished only when appropriate."[84] Therefore, the way forward must surely be greater dialogue between the professions in an attempt to decide on a mutually designed and agreed "language" and methodology in forensic psychiatry. The improvement of this dialogue was the overarching aim of the CCPS Humane Advocacy Programme ("HAP"), which addressed the need for improved forensic testimony in capital cases in the Jamaican context, caused partially by a lack of communication or understanding between the legal and psychiatric practitioners. The programme has thus far been successful in improving the quality of expert testimony, and in building bridges between the various practitioners working on such cases.

VI. THE JAMAICA HUMANE ADVOCACY PROGRAMME ("HAP")

The CCPS is piloting what is proving to be a very successful legal advocacy training project in Jamaica, with parallel training in forensic

79. *Id.* at 84, 86.

80. *Id.* at 84-88.

81. *Id.* at 84-85.

82. Nigel Eastman, *Psychiatric, Psychological, and Legal Models of Man*, 15 INT'L J. L. PSYCHIATRY 157, 157 (1992).

83. *Id.*

84. British Medical Association, *Capital and Corporal Punishment*, *in* THE MEDICAL PROFESSION AND HUMAN RIGHTS: HANDBOOK FOR A CHANGING AGENDA 185 (BMA Medical Ethics Department ed., 2001).

expertise for psychiatrists involved in capital trials.[85] In 1975, a policy decision was taken by the Jamaican government to close the forensic ward at the main mental health facility, Bellevue Hospital, resulting in patients being transferred to the General Penitentiary at Tower Street. Offenders with mental health problems are therefore kept within the hospital sections of this and other prison institutions, and in St. Catherine's Prison where those on death row are held, also within a segregated block. In 1997, the Mental Hospital Act was repealed and replaced with the Mental Health act, which alongside the Criminal Justice [Administration] Act dealt with the sentencing and disposal of mentally disordered offenders.[86] The problems caused by the holding of such offenders in the non-therapeutic environment of a prison, rather than a secure hospital, have been highlighted dramatically by cases such as those of Ivan Burrows,[87] who was "lost" in the prison system for over twenty-five years after being found unfit to plead for breaking a window. In 2004, a multidisciplinary task-force report[88] urged the government to develop a community forensic psychiatry service into which the mentally disordered would be diverted from the criminal justice system, using an existing system known as Diversion at the Point of Arrest.[89]

The issues around these changes in the Jamaican context, and the necessity for psychiatric involvement at all levels of capital cases, clearly require that practitioners in both the legal and psychiatric professions should be fully informed and trained in forensic psychiatry. Although there are a number of experienced and new psychiatrists in Jamaica, and major evaluations of mentally disordered offenders including those on death row have taken place in the past,[90] the lack of resources and manpower has caused difficulties in enabling practitioners to specialise in areas such as forensics. Local experts have identified a need for training on psychiatric defences at the first instance stage of trials, as well as on assessment of competency to stand trial. In addition the recent changes in law after the Privy Council decision in the

85. CCPS, *supra* note 1, at 10.

86. Nancy Anderson, "Workshop: Assisting the Mentally Ill in Custody, Presentation Before the Independent Jamaica Council for Human Rights, Kingston, Jamaica (Mar. 18, 2006) (on file with authors).

87. *Gov't to compensate man held for 29 years without trial*, JAMAICA OBSERVER, Jan. 28, 2003, *available at* http://www.jamaicaobserver.com/news/html/20030127t210000-0500_38740_obs_gov_t_to_compensate_man_held_for____years_without_trial.asp.

88. University of the West Indies in Kingston, Report of the Multidisciplinary Task-force of the Section of Psychiatry of the Department of Community Health and Psychiatry, Mar. 4, 2004 (Jam.) (on file with authors).

89. *Id.*

90. *See* Dr. Frederick W. Hickling et al., *A psycho-social investigation of the 36 condemned men at the St. Catherine District Prison, and the causes of the 26th December [1974] demonstration by 26 of those men*, Kingston, Jamaica (on file with authors).

Lambert Watson[91] case, which abolished the mandatory death penalty in Jamaica and required all those on death row to be re-sentenced, has demonstrated again a crucial need for the obtaining of psychiatric reports and testimony, to assist in mitigation reports to be presented before the court. It is in this context that the HAP attempted to address some of these difficulties.

CCPS' experience worldwide has shown that there is a lack of trained psychiatrists in the majority of countries where the death penalty is implemented. Furthermore, where psychiatrists are available, as in Jamaica they lack the resources to become trained in the forensic skills essential to the fairness of the capital process. Our pilot project in Jamaica has shown that this problem can be alleviated by basic forensic training on assessment, competency, and expert testimony issues, delivered by U.K. consultant forensic psychiatrists. The U.K. context is useful given the British Commonwealth backgrounds of many of the proposed countries, however the U.K. presenters have always been partnered with local psychiatrists and mental health practitioners in order to ensure the local context is appreciated. The sessions cover a variety of forensic mental health issues including, ethical issues at every stage of the capital process, assessment and awareness of competency, identifying and utilising mental health defences, and delivery of expert psychiatric testimony in capital trials.

Apart from the basic clinical training in forensic psychiatry offered to the psychiatry participants, the most innovative aspect of this programme has been the joint sessions with the advocates and psychiatrists on expert witness testimony. This takes the form of courtroom role-playing whereby advocates are trained on how to deal with psychiatric experts during examination-in-chief and cross-examination, whilst simultaneously, the experts are trained on how to deliver this evidence. One result of this has been greater communication between the two sets of practitioners as to the format the evidence should take; but, in addition, it has resulted in the psychiatry practitioners becoming more aware of the way in which the law attempts to frame their medical concepts into artificial constructs. This clearly has great implications in terms of dealing with the "cognitive dissonance"[92] that occurs when the two disciplines meet, and has hopefully gone some way to resolving the conflicts that occur and improving the quality of this very important aspect of capital cases.

The CCPS has been working in Jamaica and the British Commonwealth Caribbean with non-governmental organisations ("NGO") and civil society for several years and it was through these collaborations that the paucity of psychiatric resources was brought to its attention. Conscious always of the post-colonial dimension to our involvement it was crucial that we fully engaged with all the key people in the legal and criminal justice system,

91. Watson v. The Queen, App. No. 36 of 2003, UKPC (2004) (appeal taken from Jamaica).

92. Eastman, *supra* note 71, at 83.

academia, NGOs, and civil society. Our objectives in Jamaica, as in other countries with which we work, go beyond the particular benefits of specific projects, and built into the HAP was the capacity to develop and retain a working relationship with the "experts" and their respective professions. The U.K. psychiatrists, who continue to work with the CCPS and the HAP, have developed sound professional relationships with two of the principal psychiatrists working on forensic issues in Jamaica, who through CCPS' support have visited the U.K. and spent time immersed in the culture of forensic psychiatry. The original template programme in Jamaica placed emphasis on the psychiatry training but did not undertake civil society training. This was because local experts felt that this would be the most useful and necessary course of action given that a strong and active NGO network was already in existence, and the fact that there were a number of psychiatrists (including consultants) available to train in forensics. However, as the next section will explain, in other countries, this will not always be the case and the HAP would be adapted according to the needs and possibilities demonstrated in each country context.

In its first year, the programme of forensic training was not aimed exclusively on clinical issues, but involved a range of non-clinical mental health practitioners such as psychiatric nurses and social workers, as well as a range of criminal justice professionals, including judges and representatives of the police, probation and prison services. This was to ensure that those working throughout the legal and criminal justice system were made aware of issues relating to the role of mental health throughout the capital process. The second HAP, staged in March 2006, built on the model of the first, and at the request of the local psychiatrists focused less on NGO and criminal justice personnel participation, in order to be able to respond to the interest shown by the psychiatric community following our first programme. On this second occasion, the participants were all psychiatrists, psychiatrists in training, psychologists, and members of the Department of Psychiatry at the University of the West Indies. In addition to the programme itself, the U.K. psychiatrists were invited to run workshops at Bellevue Hospital in Kingston. The signs are auspicious for this initiative being bedded into the development of forensic psychiatric training and practice in Jamaica, and it is our intention to stage a similar programme in Trinidad and Tobago in 2007 and beyond.

VII. ADAPTING AND IMPLEMENTING THE HUMANE ADVOCACY PROGRAMME ACROSS CCPS TARGET COUNTRIES

In this section, we will focus on the potential for the adaptation and implementation of the Humane Advocacy Programme throughout the countries in which CCPS works. Since 2002, CCPS has been utilising the experience of its African-placed interns to build and share knowledge on the capital punishment systems in several former commonwealth countries in Africa,

specifically, Malawi, Uganda, Sierra Leone and Nigeria. As the majority of death penalty literature and discourse originates from the U.S., relatively little is known on the death penalty in an African context. Twenty-five states in Africa retain the death sentence in law and implement it by carrying out executions.[93] Fifteen states can be described as "abolitionist in practice" as they have not carried out an execution in ten years[94] and thirteen states have abolished the death penalty in law,[95] the most recent of which was Liberia in September 2005.[96]

The death penalty in Uganda is enshrined in its state constitution as an exception to the right to life[97] and is the mandatory penalty for murder, aggravated robbery, and treason.[98] In 2001, the Ugandan government established a Constitutional Review Commission, which considered under its Terms of Reference the abolition of the death penalty.[99] The Commission went to the public with the issue, and 57.5 percent advocated retention.[100] The Constitutional Review Commission's final report recommended retention, but advocated a mandatory sentence for only the most heinous crimes.[101] The Commission also urged the government to change the method of execution from hanging to one that could ensure instant death. A 2003 petition challenging the constitutionality of the death penalty in Uganda, *S Kigula & 417 others v. Attorney General*, was partially successful in that the Constitutional Court passed judgement in June 2005 that the mandatory

93. HOOD, *supra* note 75, at 247 app. 1, tbl.A1.1 (including: Algeria, Botswana, Burundi, Cameroon, Chad, Comoros, Congo (Democratic Republic), Egypt, Equatorial Guinea, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Libya, Morocco, Nigeria, Rwanda, Sierra Leone, Somalia, Sudan, Tanzania, Uganda, Zambia, and Zimbabwe).

94. *Id.* at 248 app. 1, tbl.A1.2 (States that have not carried out executions for the last ten years include: Benin, Burkina Faso, Central African Republic, Congo (Republic), Eritrea, Gabon, Gambia, Madagascar, Mali, Mauritania, Niger, Swaziland, Tunisia, and Togo.).

95. *Id.* at 249-50 app. 1, tbl.A1.3 (The following have abolished the death penalty: Angola, Cape Verde, Cote d'Ivoire, Djibouti, Guinea-Bissau, Mauritius, Mozambique, Namibia, Sao Tome and Principe, Seychelles, and South Africa.). Liberia has also abolished the death penalty. Death Penalty Information Center, News and Developments – International, http://www.deathpenaltyinfo.org/newsanddev/php?scid=30&scyr=2005 (last visited Apr. 17, 2006) [hereinafter News and Developments].

96. News and Developments, *supra* note 95.

97. UGANDA CONST. art. 22(1), *available at* http://www.parliament.go.ug/chapt4.htm ("No person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellate court.").

98. UGANDAN PENAL CODE §§ 189, 286(2), 25(1)-(2).

99. Hands Off Cain, Uganda, http://www.handsoffcain.org/bancadati/schedastato.php?idstato=8000387&idcontinente=25 (last visited April 6, 2006) [hereinafter Uganda].

100. Human Rights House, Uganda: Death Row Inmates Put Their Own Penalty on Trial, http://www.humanrightshouse.org/dllvis5.asp?id=2811 (last visited Apr. 6, 2006).

101. *See* Uganda, *supra* note 99.

sentence of death violated the constitution, as did a delay of beyond three years between sentence and execution.[102] The Ugandan Attorney-General appealed against these decisions, and the petitioners have cross appealed the court's judgement that the imposition of the death penalty was not per se cruel, inhuman, and degrading treatment contrary to the Ugandan Constitution, and that the method of hanging was not unconstitutional.[103] No date has yet been set for the appeals.[104]

In Sierra Leone, the death penalty is mandatory for the crimes of murder, treason, mutiny, and aggravated murder.[105] In 2005, the Truth and Reconciliation Commission ("TRC") established to investigate the causes of the civil war and to prevent a similar tragedy from recurring, published its final report, which among other recommendations, advocated that the death penalty should be expunged from the statute books.[106] The assurances of the President to honour the recommendations of the TRC have thus far not materialized. In a White Paper responding to the TRC recommendations, the government stated that: "Sierra Leone has just emerged from a decade-long armed conflict with attendant wanton killings of individuals and the commission of various atrocities, and as such does not accept the Commission's call for immediate abolition of the death penalty for persons guilty of heinous crimes."[107] The withdrawal of UNAMSIL in December 2005, has signaled a new phase in which focusing on building the capacity of local NGO's and political parties will be a crucial contribution to the future stability of the country.[108]

In Malawi, the death penalty is mandatory for the crimes of murder and treason and available, but rarely used, for certain forms of aggravated rape and

102. *See generally* International Fact-finding Mission, International Federation on Human Rights, Uganda: Challenging the Death Penalty 20, 31-32, 41-43 (2005), http://www.fidh.org/IMG/pdf/ug425a.pdf (last visited June 10, 2006) (discussing the constitutional petition of Susan Kigula, Fred Tindigwihura, Ben Ogwang and 417 others v. Attorney General).

103. Amnesty Int'l, Uganda, http://www.amnestyusa.org/countries/uganda/document.do?id=ar&yr=2006 (last visited June 11, 2006).

104. *Id.*

105. The Criminal Procedure Act of 1965, § 211(2) (Sierra Leone, amended 1974), *available at* http://www.sc-sl.org/criminal procedureact.html.

106. Commission on Human Rights, *Advisory Services and Technical Cooperation in the Field of Human Rights: Assistance to Sierra Leone in the Field of Human Rights: Report of the High Commissioner for Human Rights*, 2, 4, U.N. Doc. E/CN.4/2006/106 (Feb. 15, 2006), *available at* http://www.ohchr.org/english/bodies/ chr/docs/62chr/E.CN.4.2006.106.pdf. *See also* Amnesty Int'l, Sierra Leone, http://web.amnesty.org/report2005/sle-summary-eng (last visited Apr. 3, 2006).

107. Sierra Leone: Civil Society Criticises "Vague" Government Plan for Post-War Reform, http://www.irinnews.org/report.asp?ReportID=48098&SelectRegion=West_Africa&SelectCountry=SIERRA_LEONE (last visited Apr. 4, 2006).

108. S.C. Res. 1620, U.N. Doc. SC/1620 (Aug. 31, 2005), *available at* http://www.globalpolicy.org/security/issues/sierra/report/0831uniosl.htm.

armed robbery.[109] The last execution in Malawi took place under the regime of the former military ruler, Dr. Banda, on September 26, 1992.[110] His successor, Dr. Bakili Muluzi, repeatedly stated his opposition to capital punishment for reasons of conscience.[111] His refusal to sign death warrants led to death sentences being automatically commuted to sentences of life imprisonment.[112] It is unclear what constitutes a life sentence in Malawi, whether it is a fixed term of years, or indefinite incarceration without the possibility of parole. In May 2004, Muluzi was succeeded by President Bingu wa Mutharika.[113] In 2005, it was reported by Ken Lipenga, Minister of Information, that President Mutharika would not sign any death warrants for convicts sentenced to death.[114] The Malawi Law Commission called, in 2004, for submissions from the public for a comprehensive review of the constitution, although this process is moving very slowly.[115] The mandatory nature of the death sentence following a murder conviction leads to the Director of Public Prosecutions often charging "manslaughter" quite freely, rather than leave the question of murder to the jury, purely in an attempt to circumvent the mandatory death sentence.[116] Yet even where complete defences to murder are an element in the case, manslaughter convictions ensue, which in turn can lead to long jail sentences tantamount to a death sentence. There are currently an estimated 800 people on remand awaiting trial for murder.[117]

Capital punishment is mandatory for offences of murder and discretionary for treason and armed robbery in Nigeria under the southern Criminal Code and the northern Penal Code.[118] However, twelve of the thirty-six states, all in the north of Nigeria, have Sharia Criminal Law statutes, which criminalise sex

109. Aron Rollin, Introduction and Background, 2003 CCPS Internship Reports, http://www.wmin.ac.UK/law/page-370 (last visited Apr. 21, 2006).

110. The Quality of Justice: Trial Observations in Malawi, http://www.penalreform.org/english/dp_malawi.htm (last visited Apr. 4, 2006) [hereinafter The Quality of Justice].

111. *Id. See also* Rollin, *supra* note 109, at 1.

112. Rollin, *supra* note 109, at 1.

113. *See* Encarta, Malawi, http://encarta.msn.com/encyclopedia_761572111_4/Malawi.html (last visited June 11, 2006).

114. The World Bank, Country Brief, http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/MALAWIEXTN/0,,menuPK:355882~pagePK:141132~piPK:141107~theSitePK:355870,00.html (last visited Apr. 3, 2006).

115. Hands Off Cain, Malawi, http://www.handsoffcain.org/bancadati/schedasto.php?idcontinente=13&nome=malawi (last visited Apr. 21, 2006).

116. Malawi Law Commission, Public Notice on the Review of the Constitution, http://www.sdnp.org.mw/ruleoflaw/lawcom/constitution-revision.html (last visited Apr. 4, 2006).

117. Rollin, *supra* note 109, at 10.

118. The Quality of Justice, *supra* note 110.

outside of marriage and have evidentiary rules which greatly disadvantage women.[119]

When considering the adaptation of the HAP to other jurisdictions, it is essential to take into account the possible constraints or challenges that the implementation of this model could face. The African countries in which CCPS works, in common with Jamaica, are former members of the British Commonwealth.[120] African states inherited the Western model of law, mental health, and psychiatry from the colonial powers, including the institutionalising of mentally ill patients in the early colonial years and the establishment of asylums.[121] Most psychiatrists working in Africa have carried out their training in colonial countries. The legacy is thus sustained by the practice of African psychiatrists carrying out their training in the former colonising countries. During colonisation, the dominance of Western psychiatrists practising in Africa led to their interpretations of the African environment being expressed as fact. Asuni cites the mistaken belief that depression was rare among Africans as evidence of this.[122] Indeed many early colonial psychiatrists took the view that "psychopathic" personality traits were present in many Africans - a notion which was reportedly used to dismiss calls for independence as irrelevant.[123]

In addition to the burden of a Western colonial model of psychiatric care carried by the former Commonwealth African states, it has been noted that the experience of African psychiatrists is given insufficient exposure by journals and other academic outlets. In a survey of the six psychiatric journals, over ninety percenty of the content originated from "Euro-American" societies with Africa contributing a mere elevent percent of the total six percent of contributions which came from other countries.[124] Most psychiatric surveys carried out in prisons have been narrow in scope with a Western focus, and

119. Amnesty Int'l, *The Death Penalty in Nigeria*, at 1, AFR 44/017/2004, *available at* http://www2.amnesty.se/aidoc/external.nsf/thisweek/85251DA8B8EE7BBB80256E9B005243CE?opendocument.

120. *Id.* at 1-2.

121. *See* Tolani Asuni, *Development of Psychiatry in Africa*, *in* MENTAL HEALTH IN AFRICA AND THE AMERICAS TODAY 17, 17-18 (Samuel O. Okpaku ed., 1991). *Compare* CCPS, *supra* note 1, at 6 (mentioning the following African counties as ones in which CCPS is working: Malawi, Kenya, Nigeria, Sierra Leone, and Uganda), *with* WorldNetDaily, British Commonwealth a Popular Club: Nations Clamor for Membership in Successor of Powerful Empire, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=21707 (last visited Apr. 24, 2006) (including the following countries in a list of countries in the British Commonwealth: Kenya, Malawi, Nigeria, Sierra Leone, and Uganda).

122. Asuni, *supra* note 121, at 19.

123. Frank Njenga, *Focus on Psychiatry in East Africa*, 181 BRIT. J. PSYCHIATRY 354-59 (2002).

124. *See id*. at 356.

ninety-nine percent of available data from prison surveys is based on Western prison populations – which make up only a third of the world's prisoners.[125]

The lack of information on psychiatric services in African countries made locating data on the forensic work of psychiatrists and their involvement in trials extremely challenging. The dearth of information needs to be incorporated into future plans for adapting the HAP model to African countries.

The lack of literature on the African experience of psychiatry (which mirrors the lack of literature on the African experience of capital punishment) is symptomatic of a wider problem. The number of practising psychiatrists varies widely in African countries, from 429 registered psychiatrists in South Africa covering a population of 44 million[126] to 60 million in Kenya[127] and a sole qualified psychiatrist practising in Sierra Leone[128] and Malawi[129] for populations of 6 million and 12.6 million, respectively. In Sierra Leone, there is little provision for treatment of mental health in detention facilities. The Sierra Leone Criminal Procedure Act of 1965, dictates that mentally ill prisoners should be confined to the mental hospital in Kissy in the north of the country and requires the periodic submission of reports to enable the prisoner's case to be reviewed at least once every three years.[130] However, condemned prisoners are not permitted to be taken to Kissy Mental Hospital for security reasons, since several have escaped in the past.[131] As a result, condemned prisoners suffering from mental disorder remain in Pademba Road where no infrastructure exists to deal with mental illness.[132] There has been only one state psychiatrist in Sierra Leone in over twenty-four years.[133] Kissy Mental Hospital is undergoing refurbishment, which further restricts its capacity to

125. Vikram Patel & Athula Sumathipala, *International Representation in Psychiatric Literature: Survey of Six Leading Journals*, 178 BRIT. J. PSYCHIATRY 406, 406-07 & fig.1 (2001).

126. Robin Emsley, *Focus on Psychiatry in South Africa*, 178 BRIT. J. PSYCHIATRY 382, 383 (2001).

127. *Id*. at 383.

128. BBC News Report, *Kenya's Mix and Match Mental Health Policy* (Jan. 31, 2006), *available at* http://newsvote.bbc.co.UK/1/hi/world/africa/2998060.stm.

129. Robert Phillips & Sabrina Mahtani, *The Death Penalty in Sierra Leone*, *in* CENTRE FOR CAPITAL PUNISHMENT STUDIES: INTERNSHIP REPORTS 213, 228 (2005), *available at* http://www.wmin.ac.UK/law/pdf/INTERSHIP%20REPORT%202005.pdf.

130. Report of Dr. Robert Stewart, Volunteer Post As Honorary Lecturer in Psychiatry, College of Medicine, Blantyre, Malawi, Aug. 2005-Jul. 2006, *available at* http://www.rcpsych.ac.UK/college/spcomm/bia/Malawi-PlaceDescription.pdf.

131. The Criminal Procedures Act of 1965 §§ 71(1), 74(1); Phillips & Mahtani, *supra* note 129, at 228 (stating that prisoners suspected of mental illness should be sent to Kissy).

132. Phillips & Mahtani, *supra* note 129, at 228.

133. *Id.* at 223, 228.

admit patients - it is currently admitting a quarter of its usual capacity.[134] The facilities at Kissy are severely lacking.

Conflict has reduced the capacity for psychiatric care in African states in other ways. During the dictatorial regime of Idi Amin in Uganda in the 1970s, most medical professionals in the country were forced to emigrate or were killed.[135] In South Africa too, psychiatric services have traditionally been divided along racial lines due to apartheid.[136] The need to attract more black South African doctors to psychiatry to enable the effective development of psychiatric services was recognised as far back as 1969. Many South African psychiatrists opt to leave the country after qualification to seek better employment opportunities.[137]

Human Immunodeficiency Virus ("HIV") provides a further threat to the capacity of African states to provide psychiatric services. The psychological consequences of an HIV diagnosis and the effects of stigma is likely to put further pressure and demand for psychiatric support on a service without the capacity to cope.

There are however, some bright spots and the role of NGOs is central to addressing the shortcomings of mental health services and provisions, particularly as a large number of "low and middle income" countries (as defined by the World Health Organisation) spend less than one percent of their budget on mental health provision.[138] The advocacy work of NGO's can be pivotal in addressing antiquated mental health legislation and encouraging adoption of international standards.[139]

In Ethiopia, the lack of psychiatric personnel and the issue of decentralisation of services were addressed by training psychiatric nurses to provide mental health care in district centres around the country.[140] Thus, it would be necessary to widen the scope of the HAP beyond psychiatrists to support personnel in order for the model to have a positive impact in countries with few trained psychiatrists. In Uganda for example, efforts to promote psychiatry in medical schools are underway, in an attempt to shore up expertise to deal with the expected growth in demands on mental health services.[141]

134. *Id.* at 228.

135. Patel & Sumathipala, supra note 125, at 406-09.

136. Njenga, *supra* note 123, at 355.

137. *See* Lloyd Vogelman, *Psychology, Mental Health Care and the Future* (1990), *available at* http://www.wits.ac.za/csvr/papers/papmentl.htm (article originally published in 31 SOC. SCI. MED. 501 (1990)).

138. Emsley, *supra* note 126, at 383.

139. Shekhar Saxena & Pallab K. Maulik, *Mental Health Services in Low- and Middle-Income Countries: An Overview*, 16 CURRENT OPINION PSYCHIATRY 437, 439 (2003).

140. *Id.*

141. Atalay Alem, *Psychiatry in Ethiopia*, INT'L PSYCHIATRY, Apr. 2004, at 8, *available at* http://www.rcpsych.ac.UK/publications/ip/IP4.pdf.

Kenya has introduced new legislation in an attempt to remove the stigma of mental illness.[142] There have also been initiatives in Kenya to encourage the Western psychiatric model and the more traditional healing model to work together in collaboration, to offer training to the traditional healers concerning diagnosing those who may require admission to hospital, and to expose those trained in the Western psychiatric model to traditional treatment.[143]

VIII. CONCLUSION

This programme is but one that the CCPS has developed to inform the death penalty debate and to support countries that wish to move towards replacing capital punishment. An expanded version of the Humane Advocacy Programme will meet the objectives of improving expertise amongst those working on capital cases, disseminating research, assisting politicians to inform and lead public opinion on capital punishment, and establishing networks to address the issues of alternative sentences, minors, mental illness and mental retardation, gender, and strategies for both litigation and advocacy based abolition. The continuing necessity of our work in the Caribbean is, in part, due to the opening in April 2005 of the Caribbean Court of Justice, to replace the Privy Council as the final court of appeal for the region, considered by some to have the potential to become a "hanging court."[144] Constitutional amendments have been enacted in Barbados, which have begun to roll back a number of the protections won through the Privy Council in recent years.[145] The governments of Trinidad and Tobago, St. Lucia, and Jamaica have announced that they too are considering amending their constitutions.[146]

In this climate of hostility towards replacement and restriction of capital punishment, it is all the more vital that necessary litigation to protect the human rights of those facing the death penalty is supported and complemented by other strategies. Given the frequency, variety and gravity with which mental health issues arise in capital cases globally, a crucial component of such strategies must be to alert all those working on such cases of this situation, and to ensure that they work together effectively. The HAP has begun to facilitate this process in Jamaica, and it is to be hoped that with adaptation and adjustment, in the long-term, this and other similar programmes can increase the overall fairness of capital trials worldwide, and lead to the eventual replacement of the death penalty in the target countries.

142. Njenga, *supra* note 123, at 355.

143. *Id.*

144. BBC News Report, *supra* note 128.

145. Caribbean Court of Justice, About the Caribbean Court of Justice, http://www.caribbean courtofjustice.org/about.htm (last visited Apr. 25, 2006).

146. Hands Off Cain, Barbados, http://www.handsoffcain.org/bancadati/ schedastato.php?id stato=8000133&idcontinente=24 (last visited Apr. 6, 2006).