No. 07-1114

IN THE
Supreme Court of the United States

GARY BRADFORD CONE,
Petitioner,

v.

RICKY BELL, WARDEN,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF *AMICUS CURIAE* VETERANS FOR AMERICA IN SUPPORT OF PETITIONER

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INTEREST OF AMICUS CURIAE[1]

Veterans for America is a nonprofit advocacy and humanitarian organization that unites the newest generation of military veterans with those from past wars to advance policies favorable to veterans and elevate public discourse regarding the causes, the conduct and, particularly, the consequences of war. Veterans for America has a direct interest in the questions presented in this case. Although the specific issues presented in the petition deal with the proper scope of federal postconviction review, the substantive question ultimately at issue in this case is a matter of surpassing importance to Veterans for America – the debilitating and often tragic effects of posttraumatic stress disorder that so many of our nation's combat veterans suffer, and the relevance of that disorder to a proper assessment of their culpability in criminal cases.

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[1] No counsel for a party authored this brief in whole or in part. No person or entity other than Veterans for America and their counsel made a monetary contribution to the preparation or submission of this brief, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. Petitioner has filed blanket consent for this filing. Respondent has also consented, and pursuant to Rule 37.3, Veterans for America has filed the letter of consent with the Clerk of the Court. Veterans for America provided notice to Respondent of its intent to file this brief on March 27, 2008. Although Respondent did not receive notice of the intended filing within 10 days of the due date of the brief in opposition, it is the undersigned counsel's understanding that Respondent did receive notice of the intention of another party to file an amicus brief within that time period, and thus had an opportunity to seek additional time to file its brief in opposition.

INTRODUCTION AND SUMMARY OF ARGUMENT

The petition for certiorari sets forth, with crystalline clarity, the two ways in which the Sixth Circuit's decision in this case conflicts directly with decisions of this Court and of other courts of appeals on matters of fundamental importance. The rule articulated and applied by the Sixth Circuit – that federal postconviction review is procedurally barred when a state postconviction court refuses to consider an issue that has been "previously determined" on the merits by the state courts – flatly contravenes the holding of this Court in *Ylst v. Nunnemaker*, 501 U.S. 797 (1991). The Sixth Circuit holding also conflicts with the prevailing law in other circuits, which uniformly recognize that a state court's "previous determination" of the merits of a federal constitutional claim supports federal postconviction review, rather than forecloses it. Likewise, the Sixth Circuit's decision deepens an existing circuit conflict with respect to the question whether a federal court exercising postconviction review can look behind a state court determination of procedural default and evaluate the adequacy and independence of a state's asserted procedural bar.

Review of these questions is manifestly appropriate not merely because it would be a grave injustice to allow Petitioner Cone to be put to death without any court having considered the substance of his claim under *Brady v. Maryland*, 373 U.S. 83 (1963), but also because the articulation of uniform national rules to govern the questions raised in the petition is a matter of systemic importance.

In this brief, Veterans for America will not repeat or amplify the arguments for review set forth in the petition. Instead, we respectfully submit this brief to ensure that the Court understands that Petitioner's *Brady* claim is a powerful one on the merits, and that this case is therefore an appropriate vehicle for addressing the questions presented in the petition; there exists a very real prospect that Petitioner Cone will achieve the relief he seeks if he is given his day in federal court on the *Brady* claim. As we will demonstrate below, the substance of the defense that Cone raised both to the charge of murder and to the State's request for a death sentence – that he should not be held fully culpable because he suffers from posttraumatic stress disorder brought on by his military service, which was exacerbated by a serious drug addiction – is one that finds strong support in a well-developed body of empirical evidence, as well as decades of practical experience on the part of entities such as Veterans for America.

The sad but undeniable truth is that thousands of this nation's veterans bear the emotional and psychological scars of their battlefield service to their country – with posttraumatic stress disorder ("PTSD") chief among their afflictions. Even worse, veterans suffering from PTSD often turn to substance abuse to deaden their symptoms, bringing on a vicious cycle of self-destructive behavior. Regrettably, violence is one frequent manifestation of PTSD in the veteran population, particularly among substance abusers. A just assessment of criminal culpability requires that the nature and effects of PTSD be taken into account.

That is particularly true in this case. In seeking to win a conviction and death sentence, the prosecution did not deny that PTSD, particularly as exacerbated by the type of serious substance abuse that it so often brings about, could theoretically preclude a finding of the necessary *mens rea* or justify a "reasoned moral response" that a death sentence would be disproportionately severe. *See generally Penry v. Lynaugh*, 492 U.S. 302, 319 (1989). Instead, the prosecution challenged Cone's assertion that he suffered from PTSD and, in particular, that he was in a state of amphetamine psychosis at the time of the crime. *See* Pet. at 3-4 (detailing trial evidence presented by Cone regarding his diagnosis of PTSD and substance dependence, along with the State's response). As the prosecution would have it, Cone was not a drug user at all, much less a person suffering from a chronic addiction to powerful amphetamines that began during his service in Vietnam and deepened over time as a consequence of his PTSD.

Thus, it was particularly shocking when subsequent discovery revealed that prosecutors had suppressed exculpatory evidence that flatly contradicted the prosecution's trial strategy – evidence confirming that the authorities believed Cone to be not merely a "heavy drug user," but also a person who was generally dangerous and who appeared "frenzied" and "wild-eyed." *See* Pet. at 5-6 (describing a "wide array" of suppressed evidence that "bore directly on petitioner's defense and argument in mitigation"). This body of concealed evidence is plainly material to the core issue of

Cone's culpability. It is directly relevant to his principal defense to the charge of murder. And, it is equally relevant to the sentencers' assessment of whether Cone should have received the death penalty. The fact is that Cone's psychological make-up, his addiction to powerful amphetamines, and the criminal acts of which he was accused are all completely consistent with a diagnosis of PTSD, which is hardly surprising given Cone's traumatic combat experience in Vietnam.

As will be developed below, the PTSD-based defense that Cone sought to put forth at trial and at sentencing is well supported by a significant body of evidence. That defense should have received full and fair consideration by the jury that convicted and sentenced him. The prosecution, however, deprived the jury of the opportunity to give appropriate consideration to Cone's defense by suppressing evidence that directly supported that defense and that squarely contradicted the prosecution's statements to the jury that Cone was not a drug user at all, much less one suffering from the debilitating effects of PTSD. Because this evidence is material under any reasonable reading of *Brady*, there is every reason to think that Cone would obtain relief were he given the opportunity to adjudicate his *Brady* claim. For that reason, this case is a manifestly appropriate vehicle to consider the threshold questions Cone has raised in his petition for certiorari.

ARGUMENT

I. The Prevalence of Posttraumatic Stress Disorder, Often Combined With Substance Abuse, Is Strikingly High In Veterans.

As far back as Sophocles' *Ajax*, commentators have documented the depression, anger, and gloom that plague many soldiers long after they have returned from war. Similar perceptions about the frequency and severity of these symptoms prompted the United States to establish "the first military hospital for the insane in 1863," during the Civil War. Major Timothy P. Hayes, Jr., *Post-Traumatic Stress Disorder on Trial*, 190/191 Mil. L. Rev. 67, 70 (Winter 2006/Spring 2007). The problem received sustained attention from the relevant professional communities after the Vietnam War, leading to the official diagnostic classification of the disorder; the American Psychiatric Association listed PTSD in its *Diagnostic and Statistical Manual of Mental Disorders*, published in 1980 ("DSM-III").[2]

As the National Center for PTSD explains, the symptoms of PTSD can "disrupt" the lives of those afflicted with the condition, "making it hard to continue with . . . daily activities." National Center for PTSD, *Fact Sheet: What is Posttraumatic Stress Disorder (PTSD)*, *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_what_is_ptsd.html (last visited Mar. 27, 2008). The disorder is common in veterans. In fact, Congress was so concerned about the prevalence of PTSD after

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[2] Thus, PTSD was a clinically recognized disorder at the time Cone was convicted in 1982.

the Vietnam War that it commissioned the National Vietnam Veterans' Readjustment Study "for an investigation of posttraumatic stress disorder (PTSD) and other postwar psychological problems among Vietnam veterans" – the largest such study to date. Jennifer L. Price, National Center for PTSD, *Fact Sheet: Findings from the National Vietnam Veterans' Readjustment Study*, *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_nvvrs.html?opm=1&rr=rr45&srt=d&echorr=true (last visited Mar. 27, 2008).

Individuals suffering from PTSD often relive the combat trauma in incidents commonly referred to as "flashbacks." *See* Dr. Matthew Jaremko, Testimony in *State v. Cone*, Trial Tr. 1671-72. PTSD also often causes an emotional and social distancing from society, and consequently, from the values held in civil society. *Id.* Finally, PTSD frequently leads to stress-related symptoms, such as depression, nervousness, and sleep disorders. *Id.*

Individuals with PTSD may also suffer from other disorders, including drinking or drug problems. *See* PTSD, *Fact Sheet: What is Posttraumatic Stress Disorder*, *supra*. According to one study, "[i]ncidence estimates suggest the rates of [substance abuse] among persons with PTSD may be as high as 60%-80%. . ." Beverly Donovan & Edgardo Padin-Rivera, *Transcend: A Program for Treating PTSD and Substance Abuse in Vietnam Combat Veterans*, 8 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 51, 51 (Summer 1999). The common explanation for this high occurrence of substance abuse is the drive to "self-medicate" to treat the

symptoms and effects of PTSD. *See* Casey T. Taft, et al., *Posttraumatic Stress Disorder Symptoms, Physiological Reactivity, Alcohol Problems, and Aggression Among Military Veterans*, 116 J. Abnormal Psychol. 498, 499 (2007) (discussing self-medication and violence among those suffering from PTSD and alcohol abuse).

The impulse to self-medicate is especially high among those suffering from PTSD as a result of combat trauma. Describing a typical example of the phenomenon, professionals treating veteran-sufferers detailed, "John witnessed many atrocities during combat in Vietnam . . . Upon returning home, John often felt depressed and fearful; he was continuously agitated and always searched for the slightest sign of harm. He turned to heroin to shut out the pain." Patrick M. Reilly, H. Westley Clark, & Michael S. Shopshire, *Anger Management and PTSD: Engaging Substance Abuse Patients in Long-Term Treatment*, 6 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 68, 68 (Summer 1996). "As with many Vietnam-combat veterans, John avoided addressing traumatic incident by using drugs and alcohol." *Id.* This story reflects the experience of many: "According to the National Vietnam Veterans Readjustment Study, Vietnam veterans with PTSD are six times more likely to abuse drugs compared to Vietnam veterans without PTSD." *Id.*

Often those suffering from PTSD enter a dangerously addictive cycle. They suffer the symptoms of their disease, and then treat those symptoms through substance abuse, which only

exacerbates their distance from society and amplifies propensities towards depression, anger, and violence. The particular maladies at the heart of Mr. Cone's case, therefore, are far from "balony [*sic*]." Pet. at 3 (citing CA6 J.A. 124). Rather, the compounded effects of PTSD and substance abuse, and their prevalence in war veterans, is well-documented and serious, and there is every reason to think that Petitioner Cone was afflicted with the disorder.

II. PTSD, Particularly When Compounded By Substance Abuse, Is Directly Linked To An Increased Risk of Violent Crime.

PTSD, particularly when combined with drug and alcohol abuse, is associated with an increased proclivity for anger and violence. As the National Center for PTSD has explained, "[t]rauma can be connected with anger in many ways. After a trauma people often feel that the situation was unfair or unjust. They can't comprehend why the event has happened and why it has happened to them. These thoughts can result in intense anger." National Center for PTSD, *Fact Sheet: Common Reactions After Trauma*, *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_commonreactions.html (last visited Mar. 27, 2008). This anger can be linked to the PTSD symptom known as hyperarousal. *See* PTSD, *Fact Sheet: What is Posttraumatic Stress Disorder*, *supra*. Individuals suffering from hyperarousal "may be jittery, or always alert and on the lookout for danger." *Id.* These feelings can cause irritability, anger, and even rage. *See* National Center for PTSD, *Fact Sheet: War-Zone Related Stress*

Reactions: What Veterans Need to Know, *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/war_veteran.html?opm=1&rr=rr126&srt=d&echorr=true (last visited Mar. 28, 2008).

Hyperarousal can cause sufferers to feel "out of control. When it attains levels of intense arousal, it can be profoundly troubling to the person having the anger experience." Raymond W. Novaco, *Anger Treatment and Its Special Challenges*, 6 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 56, 58 (Summer 1996). Not surprisingly, uncontrollable anger often causes snap reactions, leading to violence and criminal acts.

Substance abuse exacerbates these effects. *See* Taft, et al., *Posttraumatic Stress*, 116 J. Abnormal Psychol. at 504 ("[H]yperarousal symptoms were associated with a greater frequency of aggression through their relationship with alcohol problems"). PTSD limits an individual's ability to control his responses to anger stimuli, and drugs and alcohol further limit the individual's capacity to deal with feelings of anger. Thus, those suffering from a combination of PTSD and substance dependence are particularly prone to commit violent acts as a result of impulses that they cannot fully control.

This risk is also elevated when those suffering from PTSD exhibit psychotic symptoms. One study found that "as many as 35% of treatment seeking veterans with PTSD may also experience psychotic symptoms that are distinct from PTSD-related perceptual disturbances (e.g., flashbacks, trauma-specific hallucinations, disassociation), and this

population represents a group of trauma survivors with significant vulnerabilities." Madeline Uddo, Frederick Sautter, & Larry Pardue, *Treatment of PTSD with Psychotic Symptoms*, 8 Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Q. 14, 14 (Winter 1998). Another study of male veterans in an inpatient PTSD facility found the numbers suffering from psychotic symptoms to be even greater: The study determined that "more than 75% of the participants [met] the criteria for at least one personality disorder." Andres R. Bollinger, et al., *Prevalence of Personality Disorders Among Combat Veterans with Posttraumatic Stress Disorder*, 13 J. Traumatic Stress 259, 263 (2000). "By comparison, personality disorders are estimated to occur in approximately 10-13% of the general population." *Id.* Certain personality disorders can cause a decreased ability to control anger and to conform one's behavior to societal demands for non-violent reactions to anger stimuli. Those suffering from these effects of PTSD – particularly when they are also inflicted with substance abuse disorders – are more likely than the general population to resort to violence.

The risk is particularly prevalent in those – like Cone – suffering from PTSD as a result of combat trauma. As one Army Captain explained about a fellow soldier who committed a murder after he returned home, in war, the soldier was taught to solve "very dangerous problems by using violence and the threat of violence as his main tools. He was congratulated and given awards for these actions. This builds in a person the propensity to deal with life's problems through violence and the threat of

violence." Deborah Sontag & Lizette Alvarez, *War Torn; Across America, Deadly Echoes of Foreign Battles,* N.Y. Times, Jan. 13, 2008 (quoting a letter from Capt. Benjamin D. Tiffner, a criminal defendant's former platoon leader, who was killed in Iraq in November 2007). An Army reservist and Iraq veteran who now works as a prosecutor in California similarly explained that in war "[y]ou are unleashing certain things in a human being we don't allow in civic society, and getting it all back in the box can be difficult for some people." *Id.* (quoting William C. Gentry).

This anecdotal evidence illustrates a problem of significant scope. In the mid-1980s, Vietnam veterans "made up a fifth of the nation's inmate population." Sontag & Alvarez, *War Torn*, *supra.* According to one study, fully a quarter of the male Vietnam Veterans with PTSD had engaged in 13 or more violent acts in the year directly preceding the study. *See* Hayes, 190/191 Mil. L. Rev. at 76-77. "[H]alf had been arrested or incarcerated multiple times as an adult." *Id.* Thus, the risk that military veterans suffering from PTSD will commit acts of violence is disturbingly high.

The risks of violence fall when afflicted individuals receive treatment. Unfortunately, many sufferers do not seek or receive proper care – particularly those whose PTSD is traceable to combat trauma. The National Vietnam Veterans' Readjustment Study revealed that "only a small number of these veterans" suffering from "a variety of psychological problems and experiencing a wide range of life-adjustment problems . . . actually sought

treatment from mental health providers." Price, National Center for PTSD, *Fact Sheet: Findings from the National Veterans' Readjustment Study*, *supra*. Some have attributed the lack of proper care during the Vietnam era to a dearth of a general understanding about the issues faced by PTSD-suffering veterans. Others have linked the problems to the veterans themselves: "Many Vietnam combat veterans diagnosed with PTSD view[ed] the VA hospital as an extension of the military, an institution for which they hold contempt." Reilly et al., *supra*, at 68.

Although treatment and understanding have surely improved since the Vietnam era, the problem of improper care among veterans persists. In a recent three-part series detailing the prevalence of violent crimes among those returning from the Afghanistan and Iraq Wars, the *New York Times* reported that many veterans suffering from PTSD worry that people, and particularly military colleagues, will view them as emotionally weak if they seek treatment for their disorder. Sontag & Alvarez, *War Torn*, *supra*. Few of these veterans receive the necessary care. In the *New York Times* analysis, reporters found that "[f]ew of the war veterans [now charged with a violent crime] received more than a cursory mental health screening at the end of their deployments . . . [m]any displayed symptoms of combat trauma after their return . . . but they were not evaluated for or received a diagnosis of posttraumatic stress disorder until after they were arrested for homicides." *Id.* Veterans forced to deal privately with the symptoms and

devastating effects of PTSD are ill-equipped to overcome impulses of anger and violence. As noted, many turn to drugs and alcohol to self-medicate and numb the feelings of anger and rage.

III. Evidence of PTSD and Related Substance Abuse Are Directly Relevant To Determining Whether a Defendant Formed the Requisite Intent to Commit a Crime and as Mitigating Evidence at Sentencing.

In cases where the defendant suffers from PTSD due to combat trauma, it is both reasonable and necessary for the trier of fact to consider whether the defendant's symptoms have affected his ability to manifest the specific intent required for conviction. Thus, in a trial for first degree murder, it is reasonable for the trier of fact to ask whether a defendant's PTSD-related symptoms of hyperarousal and/or psychosis, along with any evidence of substance abuse, render it unlikely that the defendant acted with the clear intent to kill the victim. Of course, the consideration of these factors does not require that a defendant escape culpability entirely. Rather, review of this evidence would merely go to whether the defendant formed a specific state of mind. If the court were convinced that his symptoms made it unlikely that the defendant formed the requisite mens rea for a specific intent crime, he might very well "still be guilty of a lesser" charge. 2 Wharton's Criminal Law § 141 (Charles Torcia ed. 15th ed., updated Sept. 2007).

Further, evidence of PTSD and related substance abuse may also be useful and necessary in the

sentencing phase of a trial. There, the trier of fact could reasonably determine that though the defendant is guilty of the crime, his disorders represent valid mitigating factors, leading to a downward departure in sentencing.

To ignore evidence of PTSD and related substance abuse in war veterans denies reality and betrays the safeguards in our criminal justice system. One military defense counsel has explained of PTSD-suffering veterans, "I think they should always receive some kind of consideration for the fact that their mind has been broken by war." Deborah Sontag & Lizette Alvarez, *In More Cases, Combat Trauma Is Taking The Stand*, N.Y. Times, Jan. 27, 2008. A prosecutor trying a war veteran accused of a violent crime at home remarked, "I can't justify criminal activity. But it would have been unjust to [the veteran defendant] and to society to throw out the circumstances that we as a society put him in." Deborah Sontag & Lizette Alvarez, *An Iraq Veteran's Descent; a Prosecutor's Choice*, N.Y. Times, Jan. 20, 2008. Taking it upon himself to consider the direct link between the violent symptoms of PTSD and the crime at hand, this prosecutor accepted a plea from the defendant for manslaughter, rather than murder. As such, he demonstrated a reasonable response to the complex relationship between PTSD in war veterans and violent crimes.

In vivid contrast, the prosecution in this case sought to deny Cone the opportunity to make his case that one legacy of his service in Vietnam was PTSD, that this affliction had brought about a serious drug addiction, and that he had committed

the criminal acts in question in a state of psychosis that could be traced to his afflictions. It is bad enough that the prosecution refused to disclose evidence in which officers of the State repeatedly described Cone in terms that would have directly supported his defense. But it is particularly shocking that, having suppressed this evidence, the prosecution would then try to shut down Cone's defense (both at trial and at sentencing) by falsely telling the jury that there was no evidence that Cone was a drug user at all, much less that he suffered from PTSD and a long term addiction that could have left him in the psychotic state he claimed to be in when the acts of which he was accused occurred.

Thus, because Cone's ultimate substantive claim for relief under *Brady* is a powerful one, this case is an eminently appropriate vehicle for considering the threshold issues raised in the petition.

CONCLUSION

The Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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