Center for the Study of Disability Ethics
Community Board Forum
Execution of the Mentally Disabled: A Discussion of Medical and Legal Perspectives

Introduction by Leigh B. Bienen*

The following discussion took place on August 10, 2000 at the quarterly meeting of the Community Board of the Center for the Study of Disability Ethics at the Rehabilitation Institute of Chicago in Chicago, Illinois. The Ethics Forum and Community Board includes interested ethicists, spiritual leaders, hospital staff, administrators, medical personnel, disability advocates, disability ethics scholars, and others from Northwestern University and the disability communities. For this topic, several lawyers and others with specialized experience were asked to participate in the discussion.1 Reading materials were distributed prior to the meeting.2

The United States Supreme Court has decided that the individual states shall have a great deal of autonomy on the question of how eligibility for the death penalty is defined and applied, although federal constitutional principles may control or be implicated in the decisions of state courts. Further, the United States Supreme Court has held that the Americans with Disabilities Act does apply to incarcerated persons, including persons in state correctional institutions, although the scope and interpretation of that opinion is unclear at present.3

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1. Many participated in the discussion, and a variety of views were represented. Not all who were present or contributed are credited or identified here. The Community Board meets quarterly to discuss topics in the area of disability ethics, and distributes reading materials.
As of January 1, 2001, there are a total of 3,726 inmates sentenced to death and on death row under a federal or state death sentence in the United States, and 683 persons have been executed under state authority since the reinstatement of capital punishment in 1976. Massachusetts is one of thirteen United States jurisdictions without a capital punishment statute. The law has addressed the issue of competency to be executed in a series of painful decisions involving persons sentenced to death.

All states and federal jurisdictions, as well as the traditional common law, prohibit the execution of mentally incompetent persons. The prohibition of the execution of the insane dates from the earliest British jurisprudence and has been explicitly recognized by the United States Supreme Court in Ford v. Wainwright. For purposes of this discussion, the term "mental incompetence" will be used to cover a host of mental conditions, including severe retardation, schizophrenia, lack of cognitive function due to brain injury, Alzheimer's disease, AIDS, dementia, mental incapacity, or other conditions resulting in cognitive impairment.

Many prisoners sentenced to death have severe mental problems, many have cognitive disabilities and are mentally retarded, many have drug induced mental disabilities or have suffered severe head injuries, and these conditions do not render them insane under the legal definition of insanity, or incompetent to stand trial, or incapable of being executed in the majority of states. Some will become incompetent after being sentenced, either spontaneously or because an already fragile mental condition deteriorates when the inmate has lived for several years on death row awaiting execution, often without receiving psychiatric or medical attention for a mental condition. When the execution date arrives, the person about to be executed is incapable of understanding the nature of the penalty or that he is about to be executed. This is the point when the issue of "competency to be executed" becomes ripe for a legal decision.

Alvin Ford, the habeas corpus petitioner, in the case that reached the United States Supreme Court in 1984, developed symptoms of psychoses eight years after being sentenced to death. Among other delusions, he believed that he controlled the Florida Department of Corrections and the
Governor of Florida, who was deciding upon his competency to be executed, and that Senator Kennedy, his family, and hundreds of other hostages were being tortured and required rescuing by Alvin Ford. He referred to himself as Pope John Paul and his communications were eventually reduced to code phrases repeating the word “one.”

Recently in Illinois, the Anthony Porter case explicitly raised the issue of competency to be executed. Anthony Porter’s attorney at that time, Dan Sanders, participated in the discussion reported here and talked about some of the problems with representing mentally incompetent defendants who face execution. There were many aspects to the incompetency issues raised in Anthony Porter’s case, including the fact that neither competency to stand trial nor mental mitigating factors had ever been raised in his direct or collateral appeals, or at his trial on the merits, in spite of the fact that his record clearly stated that his IQ was fifty-one. The defendant had been tried and sentenced to death without any legal authority recognizing that he was mentally retarded. Three weeks before his scheduled execution, the question of competency to be executed was raised for the first time.7

The moral foundation of criminal law provides that a criminal penalty must serve some rational purpose, even if the rationality of that purpose is minimal. No one argues that executing an insane or mentally incompetent person is rational. The grounds for collateral appeal have become increasingly restricted, and mentally incompetent people have been and will continue to be executed.8

In Penry v. Lynaugh, the United States Supreme Court rejected the argument that the defendant’s mental retardation barred his execution.9 Penry remains a controversial decision, and since the Penry decision, several

7. For a history of capital jurisprudence in Illinois, including the recent, remarkable developments resulting in the release of more than a dozen innocent persons from Illinois death row, see Leigh B. Bienen, The Quality of Justice in Capital Cases: Illinois as a Case Study, 61 LAW & CONTEMP. PROBS. 193 (1998).

8. As of August, 2000 there have been thirty-four inmates executed who were known to be mentally retarded. See Bonner & Rimer, supra note 2, at A1. As of August, 2000, a total of thirteen states had passed laws prohibiting the execution of the mentally retarded. Id. at A14. Texas has executed 239 inmates since reenactment, more than any other state and more than half of those in the term of Governor George W. Bush.

9. See 492 U.S. 302 (1989). See also Deborah W. Denno, Testing Penry and Its Progeny, 22 AM. J. CRIM. L. 1 (1994). This article includes a summary of the results of the Pennsylvania Biosocial Study, a longitudinal study of 987 subjects who were born at Philadelphia's Pennsylvania Hospital between 1959 and 1962 and then tested on a variety of mental and physical tests into their late teens. These medical records were then matched with records of juvenile arrests and convictions. “Notably lead poisoning was the strongest predictor of the subjects’ disciplinary problems in school, followed next by evidence of anemia, a frequent symptom of lead poisoning.” Id. at 47. The article also found race and poverty to be aggravating factors. See id. at 52-4.
states have individually prohibited the execution of the mentally retarded.\textsuperscript{10} In some states, persons will be executed without having any examination or investigation into mental functioning, retardation or incompetence, past or present.\textsuperscript{11} The ethical issues involving courts, state and federal expenditures, and the quality and worth of a human life, are raised sharply in the context of incarcerated persons generally and persons sentenced to death, in particular.

Recent congressional and federal court restrictions on the availability of federal habeas corpus might have prevented Alvin Ford himself from litigating the issue of his competence to be executed. As this discussion details, persons scheduled for execution may have been on death row for years or decades. While a defendant is being tried or awaiting trial, he may receive some sophisticated psychiatric attention, as the attorneys for the prosecution and defense, if they are suitably trained and capable, tease out the legal subtleties involved in the standards for competency to stand trial or the legal standards for the defense of insanity. This attention by medical and legal professionals typically disappears as soon as the inmate is sentenced to death and transferred to death row, the most restrictive and isolated confinement in the state prison system.

Staff physicians in prisons have many uncooperative, nonpaying patients, and the medical attention in some institutions may consist of unvarying maintenance doses of anti-psychotic medications. This discussion notes that the dilemmas these physicians and staff face are not simple, and the conflicts issues are multiple and contradictory. If incompetency is temporary or treatable, the law requires treating the defendant who is incompetent with psychotropic medications until he is competent to be executed and then execute him. A physician or psychologist who comes in to test death row inmates finds himself in the position of creating data which may be evidence for arguments preventing the patient’s execution, but the confidentiality of the patient-doctor relationship may be compromised from the outset.


\textsuperscript{11} For example:

Texas does not know how many of the 459 inmates on death row [as of August, 2000] are mentally retarded, said Larry Fitzgerald, a spokesman for the Texas Department of Corrections. The Prison has I.Q. test scores only for those inmates who might have been tested during an earlier incarceration, Mr. Fitzgerald said . . .

One reason for the lack of precise data about the number of mentally retarded inmates on death row is that the mentally retarded themselves struggle to hide their disability, even though in many cases it is the one thing that might save them from execution.

Bonner & Rimer, \textit{supra} note 2, at A14.
The state standards for judging incompetency for execution are what the law refers to as "two pronged": 1) whether the inmate understands the nature of the death penalty and 2) the reasons why it is being imposed upon him. The American Bar Association (ABA) has recommended an addition to the test: Whether the inmate lacks the capacity to understand or recognize any fact that might exist, which would make the punishment unjust or unlawful, or lacks the ability to convey that information to counsel or the court. At the time of this discussion, the third criteria recommended by the ABA had been adopted by three states: Montana, North Carolina, and Utah. For example, if a person is innocent of the offense, even if he could not effectively communicate that to counsel, that would fall under the third prong recommended by the ABA.

In Alvin Ford's case, three psychiatrists jointly examined the patient for thirty minutes. That may be more medical attention than most inmates being scheduled for execution receive. Two of the three psychiatrists said that Alvin Ford was clearly psychotic, and all three agreed that he was competent to be executed. The Governor of Florida refused to consider additional expert opinions submitted by the defense arguing that Alvin Ford was not competent to be executed. The Governor signed the execution warrant.¹²

When the case was decided by the United States Supreme Court, it was the procedures employed by the State, not the resulting finding of competency to be executed, which the federal constitutional court found troubling. After the decision recognizing the constitutional principle by the United States Supreme Court, there was an additional evidentiary hearing on Alvin Ford's competency to be executed. The final legal determination by the state was that Alvin Ford was competent to be executed, although he died without the assistance of the State while his case was pending on appeal. The issue of competency to be executed has recently reached the high courts of other states.¹³

As of December 1, 2000, Johnny Paul Penry, the defendant in Penry v. Lynaugh, was granted a stay of execution by the Supreme Court, after com-


¹³ In 1999, as Tennessee approached its first execution, the state realized that it had no Ford procedures in place. In Van Tran v. State, 6 S.W.3d 257 (Tenn. 1999) the Tennessee high court enacted state procedures to cover this situation, and in Coe v. State, 17 S.W.3d 193 (2000) the court affirmed the use of these procedures in the states first execution since 1960.
ing within a few days of execution in Texas.\textsuperscript{14} The Penry case remains troublesome in all of its aspects: its protracted legal proceedings, the mental state of the defendant, the competence of representation at various stages, and finally the possibility that the defendant is innocent of the murder.

At the very least, these seemingly "legal" procedural issues on the question of competence to be executed include fundamental ethical questions such as: Who can raise the claim of competency; who hires the psychiatrist, psychologist, or medical examiner; who can challenge these expert opinions; and what body adjudicates disputes over the facts. The role of the institutional staff as decision makers also was the subject of discussion in this Forum. These questions and others are addressed in the following discussion among medical and legal professionals with a variety of relevant expertise and experience.

\textsuperscript{14} See Raymond Bonner, \textit{Killer Deemed Retarded Wins Review of His Death Sentence}, N.Y. Times, Nov. 28, 2000, at A 16; see also Dina R. Hellerstein, \textit{What do We Gain by Taking These Childlike Lives?}, N.Y. Times, Dec. 1, 2000, at A37. Dina R. Hellerstein represented Terry Washington, who had the mental functioning of a seven year old, who was executed in 1997. This article parallels several comments made in the discussion reported here:

Speaking to Mr. Washington, the lawyer who represented him in his trial for the 1987 murder of Beatrice Huling may have at first concluded that his client was a shy, quiet man. A common trait of the mentally retarded is the effort to hide their disability . . . [A]t no point during the short trial did the lawyer bring the subject of Mr. Washington's mental retardation or brain damage to the attention of the judge or jury . . . ."

\textit{Id.} at A2.
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[The discussion began with the participants briefly introducing themselves.]

CO-CHAIR GILL: I am Carol Gill, the Co-Chair of the Community Board of the Center for the Study of Disability Ethics at the Rehabilitation Institute of Chicago and my Co-Chair is Henry Betts.

DR. TASWELL: I am Howard Taswell and I'm a physician retired from a career at the Mayo Clinic and now at the Chicago Center for Family Health, interested in helping people with chronic illness and disabilities.

MR. ANDERSEN: I'm Wayne Andersen. I'm a U.S. District Judge, a federal judge and I'm on the Board of the Rehabilitation Institute of Chicago (RIC). I was first involved in this institution when I heard Dr. Betts eloquently asserting, as only he can do, that the world needed to prevent injuries and I was very impressed with the mission and spirit of the people here, so I'm honored.

MS. GERAGHTY: I'm Diane Geraghty. I'm here with two hats on. I'm a Professor of Law at Loyola University, Chicago, and Director of Child and Family law practice there. My other hat is General Counsel for the American Civil Liberties Union, and I'm involved in the topic we're going to be talking about today.

MS. STINNEFORD: I'm Kate Stinneford and I'm a Financial Clearance Supervisor here and also a Senior Ethics Scholar.

MS. STANLEY: I'm Judith Stanley. I'm the Director for Accreditation with the National Commission on Correctional Health Care.* We have some handouts in the back so I don’t have to spend a lot of time telling you about us. We promote quality health care within the correctional environment. That's our particular area of expertise and we’re not-for-profit. We have been in existence about thirty years and we’re basically out of Chicago.

MR. CHAMBERS: I’m Tod Chambers. I teach Medical Ethics at Northwestern University Medical School.

* For additional information on this organization, contact Judith Stanley, M.S., Director of Accreditation, the National Commission on Correctional Health Care, 1300 W. Belmont Avenue, Chicago, Illinois 60657-3240. Tel: (773) 880-1460/Fax: (773) 880-2424.
MR. FRED: I’m Morrie Fred, a Policy Analyst with Equip for Equality, a private not-for-profit legal advocacy organization designated by the Governor to operate the federally mandated protection and advocacy system to safeguard the rights of people with physical and mental disabilities. I am also plaintiff’s co-counsel in the Harrington consent decree, a twenty-year old case dealing with the treatment of the mentally ill in Cook County Jail.

DR. KELLY: And I’m Jim Kelly. I’m a Neurologist at Northwestern and I’m on the Board.

MR. SANDERS: I’m Dan Sanders. I’m a solo practitioner attorney concentrating on criminal defense and I’m on the Board.

DR. BETTS: I’m Henry Betts. I’m a physiatrist and I was formerly Chairman of the Department of Rehabilitation here at Northwestern University Medical School.

DR. KIRSCHNER: I am Dr. Kristi Kirschner, Director of the Center for the Study of Disability Ethics and a physiatrist at RIC.

MS. BIENEN: I’m Leigh Bienen and I’m a Senior Lecturer at Northwestern University Law School and also somebody who has spent many years working in this area. We have a wide representation here of disciplines and experience. Of course, ethics does not confine itself to any one discipline; however, since we are in a hospital, I think it’s appropriate to start off with the medical people.

DR. KIRSCHNER: Well, why don’t I turn it over to Jim Kelly. We’re still waiting for Michael Gelbort to come, who’s a neuropsychologist. And Jim has considerable expertise.

DR. JIM KELLY: Thank you. I’m glad you honed that in a little bit. [Laughter] I was worried for a second. I certainly don’t consider myself an expert in ethics or on this particular topic, but I was delighted to be invited by Kristi to participate knowing what the topic was to be and then I suggested Mike Gelbort become involved and I think because a couple of other suggestions came from that direction as well, including some of the readings that were sent around.

And I have known Mike Gelbort for several years. Actually he does have a history with the Rehabilitation Institute from years ago. Michael Gelbort, a neuropsychologist now in private practice, has a large experience with death row inmates needing neuropsychological evaluations, with more than a hundred batteries of tests of death row inmates.

He has been involved on a panel of ten experts assembled at Aspen for an annual brain injury and ethics conference. One of the topics discussed there was the idea that the brain is actually responsible for the behavior we call “violence” and how does that happen. What do we know about the underpinnings of neuroanatomy, neurophysiology that lend themselves to violent behavior in humans?
There is a manuscript from that two-year consensus process of those ten experts, Mike Gelbort being one of them. What is it about the brain that we understand in terms of evolution of the brain and in terms of injury of the brain, and what has that taught us about violent behavior? The issue in brain injury is that we think, and there certainly is growing evidence, that certain disinhibitions occur with individuals where a whole variety of acquired brain injuries make them more prone, if other factors are in place, to the commission of violent acts.

It is never a single factor. It is always a multifactorial equation, and the evidence in this direction Michael Gelbort and others will speak to. It's a science in its infancy. Because of the complexity of all human behavior, its neurological underpinnings are sometimes obscured and not easily measured or identified. However, perhaps from our law experts, in particular, how it is that medicine and law come together relative to that issue has been of particular interest to us in this group and in the Aspen meetings. All of us in behavioral neurology, my subspecialty area, look at how it is that we can predict human behavior, and what interventions might be useful in ameliorating problematic behaviors and issues on a societal level. Then we hope to learn along with people outside of the medical world what other kinds of factors, what social issues, and what pressures there are that might, in fact, be adding to these considerations and problems. Obviously this is a complex issue.

MS. BIENEN: Could you just tell us a little bit more about the Aspen panel. Is there a publication that's associated with that?

DR. KELLY: That report will be coming out in the journal *Neuropsychology, Neuropsychiatry, and Behavioral Neurology*. Christopher Filley was my Fellowship Director in Behavior Neurology at the University of Colorado and he co-directs this panel and the Aspen meeting each year. Bruce Price is a Behavioral Neurologist at Massachusetts General Hospital and Harvard University. Victor Nell is a psychologist in South Africa and Chairman of a Violence Prevention Committee of the World Health Organization. Terry Antonette is a nurse and clinical specialist engaged in violence prevention strategies in adolescents in Connecticut, as is Anthony Morgan, who is a trauma surgeon in Connecticut. So he was a member there. Those connections were made through the Brain Injury Association. James Bresnahan is the founder of the Ethics Program here at Northwestern and was a member. Jonathan Pincus, who is a behavioral neurologist at

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2. See id.
3. See id.
Georgetown University and one of the early writers, at least in modern times, about brain behavior relationships and violent actions. Michael Gelbort you will meet. Michael Weisberg, is a psychiatrist at the University of Colorado and had been quite involved in dissociative reaction, psychiatric considerations in individuals who commit violent acts, and then myself. So that was the panel at the time.

MS. BIENEN: We see a striking lack of communication between the disciplines and a lot of turf wars over who has control over what territory, with the lawyers and the judges having a pretty good lock on the courts and criminal sentences, and the doctors and the medical people controlling who goes into, and what happens inside, the hospitals. Unfortunately, there is poor communication between both sides. We’re hoping to break down some of that today with the structure of this panel.

Let me comment that the whole question of genetic, behavioral, physical “causes” and associations with criminal behavior is a very controversial topic in the law. Nothing makes civil rights defense attorneys prick up their ears faster than hearing scientists or policymakers talk about the predictability of criminal behavior, or saying they are going to be able to identify who is going to commit what kinds of acts, including acts of criminal violence. A few years ago, a conference, which was scheduled to be held on the behavioral and genetic components of criminal behavior and sponsored, as I recall, by the federal government, proved to be so controversial that it was decided it could not be held in the United States, in Washington, D.C., as planned. The organizers moved it to London. So, the fact that we have many views on the subject is not unusual. For hundreds of years people have claimed to predict criminality. So let’s now turn to Judith Stanley from the National Commission on Correctional Health Care.

MS. STANLEY: The National Commission on Correctional Health Care focuses on that part of the juvenile justice system where the inmate is incarcerated — whether in jail, prison, or a Juvenile Detention Center. We’re a not-for-profit organization. Our focus is to promote quality health care, including mental health care, in all of those settings. Our concern is a little different from that of forensic psychiatry or forensic psychology. You are familiar with the field that has to do with competency to stand trial, and the legal and medical questions relating to proceeding for trial and guilt by reason of insanity or not.

There is another piece of this picture, and that is correctional health care, including correctional psychiatry, correctional psychology, and so on. What we do is provide standards for health care within the correctional setting. We run a voluntary program based on that.

Particularly germane to the topics that we are to consider today, is our concern that correctional health care, for the inmates who are incarcerated
(juvenile or adult), is provided to these citizens who are part of the public. Correctional health issues are public health issues. The majority of our inmates are returning to the community and for those that don't return to the community there are still issues of providing ethical treatment for them.

Inmates have a constitutional right to health care and, unlike you and I, they cannot freely look for or select their health care providers. The Constitution does guarantee certain basic rights to health care for them. We try to see to it that the facilities that seek our guidance are providing that health care. Our concern is that while these folks are with us they are appropriately treated.

With reference to executions, we do have concerns that certain institutions are not following health procedures. Our standard for prisons does forbid the involvement of health care workers who have a therapeutic relationship with inmates — and who are working at the prison or who are employees of prisons — from participating in executions.

We also have a position statement on competency for executions: It says that health staff who are treating the individuals scheduled for execution should not be involved in the determination of competency to be executed. It should be health staff who are not involved in the therapeutic relationship. However, we do take the position that inmates on death row are supposed to have every health care service that you or I would have and that includes mental health care. We do expect all health services and all health staff to be available and provided to the inmates on death row and that's where we stand. So, I come from a different perspective and I'm very grateful to be here. I'm a psychologist by background and I'm very interested in this topic.

MS. BIENEN: Perhaps you could say a few words about the correctional systems and their compliance with the ADA, especially the mental and cognitive aspects of that law.

MS. STANLEY: At present the situation is very confusing. It's confusing because the United States Supreme Court initially said that the ADA does apply in the correctional setting, whether it's general health or mental health, medical provisions or mental health provisions. The dilemma is the various interpretations that the state courts will, and have, put on that, and what does it mean in practice.

There are some inmates who are beginning to test the system and are asking the courts to come up with some definition. For example, if someone has high blood pressure or is on psychotropic medication and wishes to go to the work release program, is that person not going to be able to go because this program does not allow or provide for that disability? Is that system obliged to have that program open to the person with the disability, or can the system say that because it doesn't have staff to meet these special
needs, the person may not go to this program? So this area is in limbo. Our people say that some states are issuing conflicting legal opinions. Now the situation is very much in flux, and it’s a new era for the entire field.

MS. BIENEN: I believe Michael Gelbort has joined us. Welcome. Could you briefly introduce yourself and tell us about the work you have been doing with death row inmates?

DR. GELBORT: My name is Mike Gelbort. I’m a clinical neuropsychologist in private practice. I did my fellowship here sixteen years ago and have worked in various rehabilitation facilities. I got drawn into doing some forensic evaluations about ten years ago. Quickly, it progressed to the point where I was asked to do an assessment of people awaiting execution. I’ve been doing neuropsychological evaluations on death row around the country in six or eight different states and in Puerto Rico. I’ve been in several different federal penitentiaries.

I get pulled into evaluations typically on post-conviction release proceedings. People are sentenced to death. Then, when they’re going through the appeals process, there’s some concern, particularly about their neuropsychological functions. Certain laws protect their rights and, if there are any mental mitigating factors, those need to be explored. Neuropsychological evaluation is a part of that exploration.

I have done a fairly significant number of evaluations. Some of the data are included here. My major professor from graduate school and some of his team are starting to work through some of my data set, and they have put together some preliminary findings. I’m happy to discuss these results and talk about what I have seen.

MS. BIENEN: I am very interested in the fact that you interviewed and did a work up of so many death row inmates in a number of places. We also would all be interested to hear about consent procedures that you operate under, how and when you report your data, and what you do in terms of keeping the identifications of the inmates confidential.

DR. GELBORT: Well, let me address that. Consent is a little different than it is with most of the psychologists I work with. I have a regular private practice. That’s mostly what I do. Consent in these cases involving inmates is quite different. There’s not a whole lot of confidentiality. As a psychologist, I have an obligation to protect the psychological test materials. I do get into that issue with attorneys in the court system. In terms of the typical mental health consent, by and large, once an inmate agrees to participate in his evaluation, there’s not a whole lot of confidentiality other than what the legal system affords, not necessarily what the psychologist/patient relationship affords, and these can be varying standards.

In terms of protecting the data, what you see here is under the auspices of what governs psychologists generally. I do have agreements with those
who are starting to use this data set. But, by and large, the people where data have been collected, and on whom the data have been collected, have waived their right to confidentiality.

MS. STANLEY: I just want to make one comment in reference to that. This is why we do not have treating health staff involved in these evaluations, because of that problem. Once the competency evaluation is done, any relationship, privacy, or confidentiality is waived. So that is one important reason why you want to keep these activities separate.

DR. GELBORT: There are some interesting ethical issues having to do with, on the one hand, treating and, on the other hand, having what you do in the course of treatment potentially being used against the person whom you are treating. I don’t envy those physicians or staff, who are working inside the facilities and even trying to use the treatment relationship to establish rapport, when they may be working ultimately against the person.

MS. BIENEN: So are you customarily called in by correctional institutions? The courts? The defense? The state?

DR. GELBORT: Almost always I am called in by the defense. The state, or the federal government in a federal case, certainly do not want to raise these issues because it doesn’t help them if their goal is to execute someone. Occasionally the courts will call me. It depends on the court. It depends, too, on the particular judge and their past experience.

Interestingly, quite often when the court asks for this type of an evaluation, it does not necessarily, or it doesn’t give the impression, that they’re trying to find out what’s right or wrong, or to be fair with the person. Rather, the court’s concern is to preserve the legal process and to keep the process from coming back to them after an appeal. If they see that something is amiss, and they want a clean record, a clean legal record, they will ask for an evaluation, so that something wasn’t overlooked which will become grounds for appeal three years down the road.

MS. BIENEN: I think we’ll turn next to Dan Sanders who has represented Anthony Porter in the Illinois courts, his recent case involving competency to be executed, our topic today, an extremely controversial topic in the law, and one very salient now in Illinois.

Dan, can you give us some background?

MR. SANDERS: I’ll start with my own background and my experience with Anthony Porter, so you can get an idea what problems a lawyer might face with a client who has a low IQ.

I started out on the Porter case after practicing two years. I had been out of law school four years and took two years to start my own practice. I had had two capital cases by that time, so I had some training. When I took the case, Mr. Porter had already exhausted all of his appeals and pretty much had basically no hope of executive clemency.
At that time, Hector Juan Garcia, another death penalty inmate, had received clemency, and the legislature passed the rule that said that you cannot file a clemency petition unless the inmate said it was okay.

With Mr. Porter, if I mentioned the word "clemency," he became unintelligible and yelled at me for approximately half an hour. So, I could not get his permission to seek executive clemency, yet because of his mental disabilities, I had no choice.

We're here talking about legal ethics as well. I consciously violated the law and filed a clemency petition on his behalf anyway. Nobody raised a question, so I'm not sure I did violate any ethical rules.

I think when they passed the law, this was just a complicating factor that was not considered. I don't think anybody in the field or anybody that dealt with the case would disagree with that.

MS. BIENEN: When you say you violated the law, you mean you did something the client didn't want or consent to?

MR. SANDERS: I ignored the statute that said that I could only file a clemency petition with the client's consent. Certainly, the Clemency Board could have denied the petition on that ground, but I think that there is a legitimate mental health issue, and I think nobody considered what they could possibly be up against in that kind of a situation. I didn't think it was a problem in this case. If it was a problem, they could have dealt with it at that point. When I took the case, I never added any facts to the case. The professors at Northwestern never added any facts to the case.4 Everything that was there had existed for several years.

The impression Mr. Porter gave to those who dealt with him is that he was a jerk. He wouldn't talk to anybody. He would get belligerent and he couldn't be nice. After I dealt with him for a while, I realized he yelled at some attorneys and then he apologized. He said he had no other way to communicate but to yell.

I'm not a social scientist but I view that largely as a product of his environment. He grew up in Englewood. He grew up with nine brothers and sisters and a single mother in the Projects. He yelled constantly and was talking about his mother selling her house to provide his defense. She never owned a house.

So, I realized I was dealing with somebody who says what he has to say to try to convince you. You are dealing with somebody who's constantly belligerent because I think in his life that's how he got by.

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4. Anthony Porter was found to be innocent of the crimes for which he was convicted because of the efforts of Northwestern University students of Journalism and the efforts of the faculty and students of the Northwestern University School of Law. See Eric Zorn, *Death Row Inmate's Guilt As Questionable As His Mental Fitness*, CHICAGO TRIBUNE, Jan. 28, 1999, Metro Section, at 1-2.
To this day, Mr. Porter doesn’t trust me, and probably cannot. I think throughout the years nobody ever noticed any mental health problems he had because, first, his belligerent attitude overshadowed everything else and, second, because the death penalty process has largely been an “experiment.”

When I spoke to the lawyer who represented Anthony Porter before me, I asked why the lawyers had not evaluated him. Why didn’t the lawyer check him out? The lawyer’s response was, “We didn’t do it back then.” I asked several other attorneys. They all said, “We didn’t do that back then.”

We’re now learning mitigation, especially mental mitigation, is more and more important. What I have seen in recent cases is that the history of the death penalty is evolving. It is more and more and more complicated, and increasingly the process needs to involve doctors in order to understand what is wrong with these inmates.

The only reason Mr. Porter was ever evaluated mentally was to determine whether he was losing his mind because of the pendency of the execution. It was an accident that he was even evaluated for competency to be executed.

The doctor who did the evaluation came back and said, “You know, you have got a guy here with an IQ of fifty-one.” Suddenly, I had a major legal issue that for sixteen-and-half years nobody had noticed, and that I had noticed somewhat accidentally. The issue was Mr. Porter’s inability to communicate. Without that luck or chance would have resulted in his execution.

Another thing that has been mentioned in the articles is inmates refusing treatment. I have received a stack of medical reports from the Department of Corrections about one after another inmate who refused treatment, but the inmate was reported to be “fine.” This doesn’t make sense to me. I can’t understand how a doctor can determine whether an inmate is “fine” if he refuses treatment. The problem is, I think, Mr. Porter was in a setting he didn’t like. Any doctor that comes around is going to be seen as part of that setting, as the enemy. So, I can’t see how an inmate will cooperate with the Department of Corrections staff so it can get a proper evaluation of him during the ordinary course of its activities.

So, if it’s not done on the outside, and it’s not easily detectable by a lawyer who doesn’t necessarily know what to look for, you are going to end up with somebody being executed that should not be executed. I believe that the same problems exist throughout the criminal justice system. The death penalty just puts these problems under a huge microscope.

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5. Anthony Porter’s conviction was for a crime, which occurred in 1984. The Illinois Supreme Court decided his case on appeal in 1986.
I would also like to mention another one of my cases. Dr. Gelbort did a report on this case. This client was not able to tell the truth, and I think Dr. Gelbort’s report reflected that.

Well, if I have got a client that can’t tell me the truth, what can I do? If he’s got some type of psychiatric or physical problem that’s causing that, it’s beyond me or anybody else to detect. Somebody chime in if they know an answer to this.

So, you’ve got a client and a doctor’s opinion saying that the defendant is a liar. Every lawyer that’s worked on the case, including the judge in the trial, gave some hint that he understood this. Now, I can’t understand why it’s not obvious that this man has a mental problem you can’t detect, and he should not be executed.

Another thing regarding treatment in prison: It’s the Department of Corrections, not the Department of Condemnation, not the Department of Punishment. Yet, inside the institution the environment is not good.

I’m constantly getting calls from inmates who want to talk about everything, except their case. I realize some of these people do have problems and that they will whine regardless of what’s happening, and even if someone is treating them very nicely, they will complain.

There is a constant tension between guards and inmates that should not exist. It gets in the lawyers’ way. It gets in the department’s way. It costs the department a lot of money to deal with these problems. And, frankly, if they made the environment a lot nicer — if they gave the inmates opportunities, regardless if they’re condemned — prison management would be easier. An example is down in TAMs, which is probably the worst, most restricted prison in the state. The warden there has allowed some of the inmates to pursue their education. As a result, they’re not having as many problems as elsewhere.

These are some of the problems I have seen causing an inability to communicate with the client. I know medical issues or psychological issues are undetectable to the attorney who has little or no psychological training.

Dr. Gelbort mentioned that the State will not ask for a mental assessment. This makes no logical sense to me. If the State had an interest in a strong death penalty, which I personally don’t support, you would think that the State would take care to make sure it did not execute people that should not be executed.

So it seems that there’s a theme, an illogical theme, running through the way the whole system is set up. It’s also set up to be a huge experiment. If you want to treat inmates as rats in cages, I have a problem with that. I don’t think it should be that way, and that is how I’m viewing the situation today.
MS. BIENEN: When you were saying "back then" they didn't do those kinds of tests. The reference is to the mid-80s, Anthony Porter's Supreme Court case was in 1986.

MR. SANDERS: Anthony Porter started his post-conviction appeals in 1985 or 1986. His first appellate court date was 1985 or 1986. For the next several years, nobody was thinking of doing any mental fitness test.

MS. BIENEN: Could you just say a word about the current status of the Anthony Porter case, and what happened to his conviction for murder?

MR. SANDERS: The conviction for murder was vacated. We started the fitness to be executed hearing on February 1, 1999. The Thursday prior to that, Eric Zorn wrote an article in the Chicago Tribune supporting Anthony Porter's claim of innocence.

At that time, I had a recantation from William Taylor, who was the witness at the murder trial and testified against Anthony Porter. I couldn't do anything with that because all I knew was I had a liar. He had already been cross-examined on the stand. That was no help to a lawyer on post conviction.

In the judge's chambers, the prosecutor was going crazy, saying why do we have to go through with the hearing on fitness to be executed if we are going to find out he's innocent. Let's have a hearing on the innocence and come back and do the fitness hearing later. The judge sat the prosecutor down immediately and said, "We're here for the fitness hearing."

On Friday, January 29, a Northwestern University journalism student and a Northwestern professor drove to Milwaukee to talk to Inez Jackson, who had never been called as a witness or taken part in the trial. She was present for the murders. That day, they got a statement from her on film saying she was there and she saw Paul Simon, her husband, shoot the victims. When that happened, I could file a motion claiming his innocence because she had never been in court. She had never been subjected to cross-examination. I had new evidence. Nobody ever argued that we couldn't have gotten it before, so that never became an issue. Then I knew that fitness hearing was going to be pointless.

So, further drama, I called the attorney for the State. We got the judge on the phone during half time at the Super Bowl and explained what the problem was. The judge told me to call off my doctor. But we were already set up to go on Monday in federal court to show the inmate via closed circuit TV, because the federal judge wouldn't let the witnesses drive up here from the prison. And we had to show the guards and have the guards testify. So we went through with that part of the hearing.

MS. BIENEN: As to mental incompetency to be executed?
MR. SANDERS: Correct, as to mental incompetency to be executed. In the media that was represented in terms of his IQ score of fifty-one, because that’s what I believe the public believes they understand about competency.

The next day, the investigator for the defense, Paul Salino, drove to Milwaukee to talk to Inez Jackson, and he decided about 7:30 in the morning to stop at Mr. Simon’s house. Mr. Simon’s house is a bungalow-style house, very long, with the front room, the living room, and a back room and a TV facing a mirrored wall. Mr. Salino brought in the videotape that he had made of the gentleman claiming that he was there when the killing occurred.

Mr. Simon looked at the tape, laughed, and said, “That’s not real.” Then, Paul Salino looked in the mirror and noticed the videotape they had made of Inez Jackson was being shown on TV. So he said to Mr. Simon, “Come here.” They went to the back of the house and on the TV he sees a woman pointing him out and saying, “My husband did it.” Shortly after that, after the detective led him to believe the authorities were probably on the way, he folded and gave the videotaped confession that he committed the murders.

The next day, we gave the tapes of the confession to the State. Thursday morning, I called them and said, “I assume you want to meet.” All day long they were trying to plan the meeting. At the end of the day they told me, “Okay, we’re meeting tomorrow at 10 o’clock. Do not tell anybody.” So I didn’t tell anybody.

The next morning, I show up at the criminal court and see about 500 reporters, and I’m wondering what’s going on here? So, we go upstairs into the library of the State’s Attorney’s office. Tom Gaynor, who was the prosecutor on the case, was there. The State’s Attorney’s First Assistant was there. They walked in, and to our surprise, he said, “How about if we let Mr. Porter out on an I-Bond,” which is a recognizance bond. We didn’t object. However, they weren’t willing to get rid of the conviction that day. I had a person facing a double murder charge out on a recognizance bond.

So, I think that told us where we were going and that we were probably going to get rid of the conviction. The judge then ordered his release, and he was released within fifteen minutes, the fastest I have ever seen anybody come out of Cook County Jail. I jokingly suggested we get a limousine to drive him home. We weren’t able to do that, but CBS provided him with a car.

As we were driving, Mr. Porter would see things. One comment of his stuck in my mind. He said, “There’s a dog.” I don’t think he had seen a dog in years and years, and years. Then he saw a McDonald’s, and we went from the right lane across three or four lanes of traffic — with about forty cars behind us and a helicopter above us — and we went to McDonald’s.
He had his first McDonald’s in over sixteen years. It was quite astounding to watch him see the world again after sixteen years.

One last thing. When Mr. Porter was brought up from the prison, he was evaluated here in Chicago. He left the prison I think at three or four in the morning. He hadn’t been out of prison in sixteen years. They brought him up to the Medical Institute for a clinical series to be evaluated. He had been up all day, brought to jail, driven in shackles and handcuffs, and then brought down a long hallway that I have never seen. It took him about an hour to get to the doctor’s office. He looked out the window and he saw all these things going on and all he could do is stare out the window. The doctor tried to evaluate him, and the report said he was malingering.

Now, I don’t think he was malingering. I think he was surprised, which is not to say that he didn’t mangle on other occasions. He may have. A person of his IQ can be malingering, which benefited the defense. But once I had an IQ test, the State couldn’t touch him, even if he was malingering. That’s all the doctor could say.

Again, we had a problem. We were sent to a doctor to evaluate a client who had been run through the ringer that morning, who had not seen the outside world from the sixty-seventh floor or tenth floor in years and years, and that was his focus. And this made the medical evaluation worthless. That’s another problem.

MS. BIENEN: One thing your narrative illustrates for all of us is how legal events can assume a momentum of their own and are often influenced by accidental circumstances, or the role of the media, with events snowballing out of the control of the attorney, the judge, or anyone else. Also, you point out for us again that the legal definition of mental disability and impairment, which is an issue also at the time of the imposition of the death penalty at the penalty phase of the trial, is very different from the legal definition of mental competency to be executed. All of these definitions are distinct from one another and from the medical definitions of various forms of mental illness or disability. There’s no way to escape that contradiction.

Let’s continue the discussion. I’d like to turn next to Diane Geraghty for her comments upon these issues and the distinctions we see here.

MS. GERAGHTY: I thought I would begin by saying how timely this meeting is.

As some of you may have heard in the news today on August 9, 2000, Texas executed, within the space of thirty-three minutes, two individuals, including one person who had an IQ of sixty-three. The prosecutor’s remarks in Texas at the time were that his low IQ made him more dangerous, and strengthened the argument that he should be put to death. We see the intersection of the law and mental disability in that statement.
Earlier, I mentioned that my particular interest is children and youth, and this has particular saliency in the United States. This is one of the few countries in the world that executes children, and there you have issues of competency raised simply because of the disability of youth.

I want in my introductory remarks to talk about the various stages in which health professionals are involved in capital cases and to tie that up with something that was said earlier.

The earliest stage where the health professionals are involved, of course, is at the pretrial and at the trial stage. There, you can have issues having to do with the competency of the person to stand trial, or the competency of the person to be sentenced. There is a long history in both the common law, and then in constitutional law, that governs those determinations. In a death penalty case, mental mitigating factors, including mental disabilities, are directly relevant to sentencing. And that is a special, unique set of standards.

A second stage is when a person is on death row. There, a variety of kinds of medical interventions take place, some having to do simply with the medical health of these individuals and some having to do with the execution itself.

The question of treating somebody who's incompetent to be executed so that they can be executed is one of these issues. The whole question about whether or not an incompetent person can accept mental health treatment, or refuse mental health treatment, raises interesting ethical issues. Then, of course, the final stage, potentially, is participation of the medical physician in the carrying out of the execution itself. Some states require a physician, for example, to be present at the time of the execution.

Most of the readings have to do with the execution of persons who suffer from a mental illness. The United States Supreme Court has said persons who are insane cannot be constitutionally executed. However, insanity, as you know, is not necessarily a permanent circumstance. So, one question is whether or not an insane person can be returned to a state of sanity so that person can, in fact, constitutionally be executed. The United States Supreme Court has said that it's not a *per se* violation of the Constitution to execute the retarded. A person who cannot by definition be treated out of his or her mental circumstances, by being profoundly retarded (as we saw in Texas last night) under the law, is subject to having the death sentence carried out.

Having set out those stages, the point I would like to make to you is how important it is for those in the justice system, and those in the medical profession, to work together at the front end of the process of the capital case. Dr. Gelbort's work is an example of having to be focused on those final months, and days, and hours of a capital case.
We have a flawed death penalty system in this state. The Governor has recognized that, but part of the flaw in that system is that we don’t have good legal representation for defendants accused of capital crimes. Good legal representation in these kinds of cases by definition requires an interdisciplinary approach to the representation of a client and being able to access the resources of the mental health profession and the medical profession early on in this process. This early cooperation not only provides the best legal representation, it invokes the fewest ethical issues for the medical health professionals.

I don’t think that there’s any doubt that it’s ethical for a psychiatrist or psychologist to testify at trial originally about someone’s IQ, or about someone’s sanity, or about someone’s capacity to stand trial or be executed. But the ethical issues become very complex as you move through that process closer to the execution.

The Medical Association, and the American Bar Association, for example, say it is unethical for physicians to participate at that final stage or to actually participate in the execution itself. So, an interdisciplinary approach at the front end of the process is something I hope will be an important outgrowth of today’s session.

MR. SANDERS: May I add something to that? I think specifically such early intervention is needed in evaluating the statements made to the police. Individuals with a low IQ can go to a police station and not know why they are there. They want to help the police and they confess. Then, the same individual sees a lawyer once he’s in trouble and wants to help the lawyer, and he tells the lawyer something totally different.

There was recently an instance where a person was in prison because he had confessed to a crime, and it was shown that somebody else committed the crime. This can be a real problem. Even before trial, if you have a statement made by a defendant, you have to get the doctors involved immediately to tell you whether the statement was probably not factually true.

MS. BIENEN: Of course, let us turn to the ethical issues. It’s impossible to extricate them from the legal and medical issues. Why would we think that all of a sudden we are going to have a solution to what has been one of the most fundamental problems, not only for our society, but for all societies; namely, for what acts should we hold a person responsible? What justifies removing a person from society, either by putting them in prison, or banishment, or by execution, by taking somebody’s life? What criteria are we going to use to determine, and measure these judgements? What

does responsibility mean for somebody who commits acts, which are considered to be antisocial or against the law?

Traditionally, under British Common Law, a child of seven is held to be criminally responsible. It is not against the Constitution or the laws of the United States to execute a mentally retarded person, although thirteen individual states have now said that you cannot impose the death penalty on a mentally retarded person. These statutes are relatively recent. This is very much what we call an evolving area of the law.

I would like to turn next, before we open this up for general discussion, to Morris Fred. You are the perfect person, as an anthropologist and an attorney, and somebody who has worked with inmates, to talk about the interdisciplinary aspect of these problems.

MR. FRED: I want to pick on Diane Geraghty's remarks about the need for different professionals to start talking to each other earlier in the process. I should note that although I have never worked directly in a death row case, I see analogous problems in my work with the treatment of the mentally ill in Cook County Jail and thus want to advocate for the interdisciplinary approach to these issues.

First, I want to commend the fact that we have begun to discuss the significance of the ways that different cultures perceive right and wrong. Can we say that values inherent in our laws and the legal system itself, are universal, or are they culture-bound? What, if any, impact this has on the criminal justice system in multicultural America is a question that should concern us.

This issue touches many areas and points to the importance that an interdisciplinary approach can have in reaching a just and fair decision in specific cases. Unfortunately, what I have sometimes experienced is that while various disciplines may be included in a particular case, the process is often quite mechanical rather than organic. What may happen is that a lawyer will decide to call on a social worker or a doctor for an expert opinion, but the context for that opinion has already been determined by the attorney. This, I would suggest, is too late in the process. What needs to happen instead is that already in the preparatory stages of a case, an effort should be made to integrate those viewpoints into the overall legal strategy.

Taking another example, I am now seeking the advantage as well as challenges of disciplinary inclusiveness in the work I have begun doing on guardianship reform in the state of Illinois. Here, the assessment of decisional impairment, the basis of whether or not a person needs a guardian, represents a situation where interdisciplinary cooperation is both valuable and necessary. There is a legal standard to determine guardianship, but more often than not, the court, in deciding about the need for a guardian, depends almost entirely on a physician's report about a person's decisional
capacity. Thus, because of possible unintentional commingling of legal and medical standards in guardianship proceedings, there can be a definite benefit to clarifying cross-disciplinary communication at an early stage in the process.

MS. BIENEN: Of course, all of the disciplines give us a place to hide while we are faced with an impossible problem, that is also a practical problem: An individual who’s causing trouble or has committed terrible crimes. There is no solution or easy way out. We lawyers can say it’s the doctor’s problem. It’s the social worker’s problem. It’s the court’s problem. It’s the correctional institution’s problem. It’s the family’s problem. It’s a cultural problem. This allows us to hide the problem under one of many shells, and a disciplinary shell game goes on. Our disciplines encourage us to do that, it seems to me.

DR. KIRSCHNER: I would like to make a few comments from the perspective of rehabilitation and brain injuries. I’ve been very struck over the years by how profound the consequences brain injury has on behavior. For example, disinhibition syndromes are well recognized with some types of frontal lobe injuries. There is a growing body of literature about unrecognized brain injury in the criminal population.

Jim Kelly, perhaps you want to say more about that. I think it’s clear that many unrecognized brain injuries occur in childhood, and may have profound consequences in terms of development and sociopathic personalities. Not knowing about these injuries, and not knowing how to look for them, can make it very difficult to interpret these behaviors and understand how much actual control a person may have over his or her own behavior and how much their behavior may be modified.

DR. KELLY: I think the evidence is now that injuries to specific areas of the brain are becoming more likely to be one of the multiple factors in the whole evolution of human behavior, from childhood injury or some other acquired injury. One, Michael Gelbort’s papers referred to research by others about specific frontal lobe areas that seem to be associated with certain types of sociopathic behaviors, or something akin to that. That science is emerging still. We are looking more and more at functional imaging components of this and what that has to offer.

Neuropsychological testing has become more sophisticated over the last decade. What we are able to study is much more expanded. So, we are really just now learning how to draw these connections. We don’t want to leap too far ahead of what the evidence will support. There’s considerable energy directed to this area.

MS. BIENEN: Michael Gelbort, do you want to add anything to that; particularly, with regard to the patterns that we read about with MRI’s, and drug use, and Alzheimer’s?
DR. GELBORT: The biggest change is certainly that science is marching ahead. The legal community is starting to realize that the answers that need to be brought out into the light are outside of the law. My observation has been that in the past ten years the biggest change has been that lawyers no longer think about these cases just based on the way the law works. They have started turning to other professionals, mental health and medical professionals, for an explanation and understanding of behavior.

There tends to be not a whole lot of disagreement as to whether or not people are doing bad things, but now the focus has been on why. With that focus there’s more requests to look inside the brain and a recognition that we owe it to society to understand what motivates these sorts of behaviors. Hence, more people are interested in assessments and evaluation from my area of neuroscience. More people are interested in understanding medical work ups, and in using some of the more sophisticated techniques to see what’s actually going on in the brain with these folks.

A case in point is that there have been way too many lawyers whom I have worked with on cases who complain to me that the patient, my patient, their client, is explosive and won’t answer their questions. Lawyers say that they are tangential, and the client won’t answer their questions, that the client does not seem to be able to come up with the information, that the client does not remember what it is necessary for the lawyer to know to mount a proper legal defense.

I find myself again and again saying, “but don’t you understand?” That’s what we’re talking about. That’s the person. There’s something wrong with the person, such that they’re not able to communicate with you normally. That may not be the basis for a defense to the criminal action, or behavior, but it is the basis for an understanding of why they act as they do.

MS. BIENEN: With regard to the mental retardation issue, in the New York Times article distributed, there was an estimate quoted of something like ten percent of the people on death row being mentally retarded. I, myself, think that estimate is far too low. I think it’s probably more like thirty or forty percent, but that’s just a guess on my part, and I would expand that figure not just to people on death row, but also to people incarcerated in jails and prisons generally.

It’s also striking in our readings that if you look at the commentary by the lawyers, the two Law Review articles, and the scientific papers by the medical authors, and then at the New York Times piece, you have a perfect array of the very different styles of discourse and forms of address that fit these various disciplines. The journalist is trying to bridge the gap between the professional disciplines, often performing a very good service by reporting upon complicated, overlapping issues with some factual depth.
Mental retardation brings us to the issue of disability and one whole question concerning mental retardation; namely, when did it occur and what was the cause of it? Is it brain injury? Is it head injury? Is it birth injury, and how is that classified? And does that mean that the person presents certain identifiable characteristics that can be brought up in his defense in the capital trial, or do these conditions not meet the legal criteria for mental mitigation or competence? Also, what does retardation mean in terms of disability and the person's qualifications and eligibility under the Americans with Disabilities Act? And I would like to hear some specific comments on that from the rehabilitation and disability perspective.

CO-CHAIR GILL: In reading the articles and hearing the discussions today, I'm increasingly struck by questions of class in all of these issues and how class figures in.

First of all, look at populations of the prisons and who gets on death row. There is real selection there in that people, who have less money, are more oppressed socially, and are more likely to be in prison, to be victims of the system. They're also more likely to be exposed to impairment-causing factors; for example, environmental factors. They are more likely to score lower on IQ tests, because those are not conceived on a norm for people who are socially oppressed and marginalized.

The articles that show associations between low IQ indicators or mental retardation and brain injury, also mention behavioral indicators, deviations from a social consensus on what's appropriate behavior and what's not. Again, I have a hard time separating out the influence of class from disability. It almost seems to me that there's a constellation of mitigating factors that one always has to look at when someone is on death row. A lot of it is not just disability, and biological variables, or cognitive variables, but it is social variability as well. Some of these variables hang together in what could be called "disability" and that becomes a subcategory that gets a particular social response. And the social response is, "I think, oh, that person is sick." Then our ethicists want to protect, want to nurture, take care of, make safe, want to excuse this person because of the sickness.

So, I'm wondering if in some way society uses this construct "disability" for a sickness, in order to say, "okay, there are some mitigating factors that we will accept as legal mitigating factors. Then, those other people we're going to reject and say the legal mitigating factors don't apply to them."

MS. BIENEN: People who work with death row inmates and correctional officers are very aware of the class issues you raise. You are absolutely right on the money raising those class issues. And let's not forget race and racial discrimination as a factor in this issue. The racial issue is compounded by class issues throughout the system.
Of course, it's also true that if you are representing a client who you think is going to death row on a railroad train, you will try anything in your legal repertoire to get that client off of that train or to get your client off of death row when you find them on death row.

So, a certain amount of criticism develops on the part of the general public, and also on the part of people who are not lawyers about that. They say that clients are faking or malingering, and they're pretending to have a mental disability when they don't. That raises a whole other set of issues.

CO-CHAIR GILL: Probably prisoners have legitimate claims to a lot of mitigating variables, but some of them get that response because of the way society is defining disability ambivalently, as society reacts to disability. "Disability" is an opening for clients and attorneys to use when there probably are so many other circumstances that are equally legitimate, but not as popular or socially acceptable.

MS. BIENEN: A very skilled attorney, again, an attorney who knows how to develop some of this anthropological, and social, and cultural evidence can bring it in, especially in the penalty phase hearing of a death case, because the law provides that: "Any other evidence which will mitigate against the death sentence" can be brought before the jury or the judge. Unfortunately all too often that kind of evidence, social and cultural evidence, is not brought in, and the jury does not get a chance to hear it.

COMMENT FROM THE PANEL: Carol, are you saying the disability community may have an interest in disassociating cognitively-impaired criminals from the disabled community?

CO-CHAIR GILL: No. No, not at all. What I'm saying is there's a real affinity between the interests of people with disabilities, and the criminal justice issues involving people with disabilities in that both involve people of the oppressed class. I think there is almost a continuum there of oppression and injustice, and a legitimate claim to mitigating circumstances on those grounds.

What I'm suggesting is that society has been disingenuous. Here's all of this information about how society and the law protects people when they are going to prison, and people may in fact be committing crimes or acting out violently. Then, society sort of lets itself off the hook by saying, "But there are some legitimately sick people, so we are going to open our hearts and make sure that there are laws to protect just them." That sort of gives license to society to not be so concerned about other issues that are just as oppressive. Of course, the legal system will use anything that promotes justice.

MS. BIENEN: But to further elaborate on that, and I think your point is very well taken, what we see is the economic, medical, social, and cultural factors acting together. Anybody who has worked on capital cases knows
that defense attorneys who are not paid enough, or who are not properly compensated, or not properly trained, which, of course, is another way of saying not paid enough, that this results in poor people being sentenced to death much more often than a rich person who could afford competent counsel and avoid the death penalty.

I don’t say the distinction is between public and private counsel, because the system is different in every jurisdiction. In some jurisdictions the public defenders are the best attorneys, the most skilled, and the most knowledgeable capital defense attorneys.

Death penalty advocates in other jurisdictions, private counsel, will have more resources. So it is not simply a public/private distinction. Sometimes that issue also gets muddied in the discussion. But it is very much a question of resources and how resources are devoted to an appropriate legal defense at every stage of the process.

By the way, a proposed bill to ban the execution of the mentally retarded passed the Illinois State House and was stalled in the Senate this year, so that is where Illinois stands. I don’t think we have seen the end of this issue in Illinois.

I would like to turn to Wayne Andersen, next.

JUDGE ANDERSEN: With a group this illustrious one tends to try to seem profound, but then one is going to look dumb, because there are a lot of people who know more than I know. Ultimately I’m in a situation where I have to make some decisions. I think it’s important for not only the lawyers but also for the society that passes the laws and creates the laws to understand the perspective a judge has.

First of all, in the federal system, the judges generally aren’t experts in anything. We generalize. I have had one death penalty case, and I spent a huge amount of time on it. In fact, it’s kind of depressing the amount of time I spent on it. I think in a way the system shouldn’t be spending this time and resources on the death penalty. Let’s say that was the end of the death penalty debate. No more death penalty. So that would mean judges are going to give life sentences and there’s probably not going to be any focus, or little focus, on the mental health, issues, let alone the other disabilities of people who are incarcerated.

The drama of the death penalty brings factors to bear on doctors and psychologists. I agree that there is a tremendous amount of mental illness and mental disability throughout the criminal justice system.

Frankly, without diminishing the value of the lives of the people on death row, I would venture to say a majority of the bank robbers I see are mentally ill, single men who go off their medication. Our society does not provide reasonable custodial care for them. So they decide, sometimes willingly, sometimes unwillingly, to rob a bank so they can get in a federal
prison where they can regularly take medication. And their lawyers may be jumping up and down trying to exonerate them because they’re not mentally competent to enter into a plea or to be found guilty of the crime. Indeed, the results of the lawyers’ legal success may be to force them back on the street where they get hit over the head and may become physically disabled and live a shorter and tougher life than if they had gone to federal prison.

I think when we’re dealing with the mentally ill, we have to decide what the goal is. As a citizen, and a judge, I wish that there were more focus on what we can do to reduce mental impairments and to deal with mental disability before it gets to the death penalty stage.

I would bet ninety-nine percent or ninety percent of the people who are condemned to death have earlier committed lesser crimes, crimes for which they had just made a deal and were let go. In Cook County particularly, it’s not unusual for someone to get arrested ten and twenty times and never be convicted of anything, and therefore not get any kind of treatment.

Be that as it may, judges are guessing in the literal sense of the word. We are trying to do our best, insofar as mental health issues are involved. Lawyers are trained by our society to be adversaries. Generally, defense lawyers are trained to try to mitigate punishment, and prosecutors are trained to maximize punishment. I don’t think when you are dealing with the mentally ill that it ought to be an adversarial process. I wish that defense counsel, and the prosecutors, and a judge could sit down and say, “What’s the best thing to do here for society, as well as for the individual.”

Our society has a dilemma. We’re a very individualistic society, and thank God we are individuals. But the fact is that society is not going to tolerate people getting killed, banks getting robbed, people getting raped, and things like that.

Insofar as society believes we can reduce these events, as we have, by tougher criminal laws, and by putting more people in prison, I think there’s a lack of caring by society in general for the people in prison, which almost makes the debate that we’re having beside the point.

So the point is, how can we get society to care enough so that mental disability can be recognized early on and treated, so that it doesn’t come up first in the criminal justice system, and certainly so that it doesn’t come into the criminal justice system only at the end stage? I don’t know exactly how that can be done, except for us to try to make people care more about the mentally disabled and to make society in general care more about the mentally disabled.

I agree about the commitment to medical care in prison. I do not believe that society, that our elected officials, are ever going to appropriate nearly enough money to provide what any person in this room considers to be
good medical treatment in prison. It happens on an occasional basis, if you happen to be in Rochester, and you happen to need a sophisticated operation and go to the Mayo clinic. But that’s the exception, not the rule.

So, I think it is whistling in the wind to say, “We’re going to get really good medical care in dealing with mental disabilities in prison or on death row.” I think we ought to deal with these issues earlier rather than later. If the debate we are having about the death penalty results in abolishing the death penalty, I’m not sure anyone with disabilities is going to be helped. I think what will happen is that persons with mental disabilities will just get sent to prison for life and nobody’s going to care about them in that situation.

So, I think we need to intervene earlier in people’s lives, and we need to show, if that’s going to require some kind of government action, that such interventions can be done without jeopardizing the safety of the public; and that it can be done in a cost-effective way, in the narrow sense of that word.

If those opposed to the death penalty succeed, I predict they’re going to succeed not based on the theory that the State shouldn’t take a person’s life, even though the person might be innocent, but because of the costs of litigating death penalty cases. We want to punish criminals but only when they willfully commit the crime. We do not want to punish people who are insane or seriously mentally disabled, because they don’t have the will to commit the crime.

The cost of resolving that conflict has not yet become so great in terms of hiring psychologists, psychiatrists, doctors, lawyers, judges, and court reporters that society wants to avoid the cost by abolishing the death penalty. But that day may come.

I think if we are going to really make society better, what we should be focusing on is not saving the relatively few lives of the people who end up on death row improperly. I don’t mean to diminish that, but I think we need to look at what we can do to intervene early in the lives of people that are identified with a mental disability. And a prerequisite to doing that is educating the public to the notion that there is something that can be done. Particularly in America we want to believe we’re responsible for our own actions and that free will is what governs us.

Insofar as modern medicine is teaching us that there are chemical things or biological things going on in our brain that we don’t control, or that can produce bad or criminal behavior, I would suggest that that message be published. But that these facts not just be published in any way, but in a responsible way. What do we do? Do we let people keep robbing convenience stores? These results can be published in a way that says, “Here is what we can do about it.”
I personally advocate starting a long-term program to try to get more care for the mentally ill at every level and hoping then that fewer people are sent to death row. I think it’s important that we not leave this room advocating merely an understanding that the system is flawed. It’s human. It is flawed. Advocating that a handful of people who end up on death row get even more resources is not the answer. The younger criminals in the juvenile system just get pushed out waiting for the day when they do something so bad that they come in after the fact.

DR. KIRSCHNER: I was just going to say that is what happens today. We should be looking at and understanding the markers of criminal behavior, juvenile traits, and tracking down and trying to look at populations to see if we can pick up some of these early signs and markers so we can figure out how to intervene.

DR. TASWELL: I wonder if I could point to a couple of things that have been said very richly around the table and invite us to explore them a little bit further.

The first is the notion of cause and responsibility, especially as the judge has just invited us to think about this. We do have a deeply ingrained moral conviction that we need to take responsibility for the things that we do, even if they’re caused by specific neurochemicals that maybe cause the behavior. Yet, when we deal with specific neurochemicals that cause the disorder, we suddenly have got cognitive dissonance. We’re not sure we’re responsible for those things any more.

I think a deep moral intuition is that it’s not just the final criminal or causal act that needs to be taken into account. When you talk about a more caring society, we implicitly acknowledge the whole person.

The Porter case was a circumstance of his upbringing. It was all kinds of things that were causally related to the ultimate situation that came to a head. So, if we are going to engage in this whole conversation, we are going to have to go back and think about cause and responsibility, and which of the many things that contribute to any individual event are we going to take responsibility for? What can we not take responsibility for? And then what do we do? How do we take responsibility without blaming? What is the difference between blaming and taking responsibility? Some of these questions are, it seems, awfully intangible and conceptual. Actually, that’s what we’re talking about.

We are going to have to get there and, I hate to say this because it’s going to be even more difficult, but we’re going to have to deal with genetics as well when we get to those questions. It’s going to turn out that some of these conditions are genetically predisposed.

We are going to have to go back to the word you mentioned right at the beginning, predictability. There is already a public debate about the argu-
ments for using genetic knowledge to treat. So that debate is moving fast, and we are going to have to get there too. That’s one very big factor. I’m not making things easier. I realize I’m making things harder.

The other very big debate is the interdisciplinary attempt in trying to move upstream. This is going to lead us to all kinds of crossing of boundaries that we want but that we undertake with known difficulty.

I’m a doctor. Let’s say I’m going into a criminal system and I’m trying to work with an interdisciplinary team. Am I working to provide the care of that person, the medical care, the social care? What kind of care? Am I just evaluating that person? Am I trying to be a partner in an interdisciplinary team seeking justice? Justice for whom? For the defendant? For the other side? For the society at large?

It’s precisely the extent of those boundaries which help us to be professionals, which makes it okay for a lawyer to fight against the other side; whereas, a physician can never fight against another patient, even if they’re not that doctor’s patient, precisely. Loosening these boundaries, which make us able to be professionals, how are we going to do that?

I’m sorry I didn’t make anything easier at all, but I am inviting an exploration of an even more difficult sets of issues. I think we have to do this.

MS. BIENEN: Thank you. Also, I’m very interested in your bringing up the duality of responsibility, on the one hand, your implicit reference to the responsibility of the society for the people within it, both in terms of taking care of those people at all stages and also the society’s being responsible for people being brought up, or living in, conditions which may have an influence upon their later development and the kind of people they become. Of course, all of that is very much intertwined with the issue of what is personal responsibility and what is criminal responsibility, and how that is related to awareness and coherence of the individual himself or herself, who is being held responsible under the law.

MS. STINNEFORD: When I was reading the articles, I kept taking the death penalty out of this because, philosophically, I’m opposed to it, period. I think if there’s no death penalty, how does that affect the argument?

Part of what occurred to me is it almost seems as if we are making an assumption that if you have a mental disability, or are mentally retarded, you are, therefore, not responsible for your actions. I don’t think that’s true either.

I think there are certain types of mental disabilities, or certain degrees of mental retardation, where that may be a factor. I don’t think with some of the examples given that I would be troubled to lose the personal responsibility part of it. One way or the other, somebody with that level of disability should either get free, or they should be sent to prison for life. I think there’s got to be some of both.
MS. BIENEN: I think the death penalty is the whirlpool by the large stream, with the large stream being the criminal justice system. More than a million-and-a-half people are incarcerated in the United States, one of the highest rates of imprisonment in the world. And over 3,700 people are on death row in the United States, all but a few under the authority of the states.

MR. CHAMBERS: I'm actually interested in Carol's argument. I'm also concerned about the arguments that have been made about predictability for people that have a mental illness and a history of violence. It just seems to me you are not finding upper middle class people ending up in the same violent situations. So, the factors that you can find in a whole bunch of people can't be the sole cause of violence, perhaps because they have very good lawyers when they commit violent acts, which is a possibility, but I suspect something else is also a factor.

I am also somewhat worried about something that was raised in the article on the issue of consent, the concept under which prisoners consent to have the results of their tests be used for research. As much as I agree with the reason that the defense is calling for help from these people, I wonder also about the informed consent process here, and whether a patient is able to understand what's going on and, therefore, able to consent to treatment or refuse treatment.

In the State of Illinois, we force people into hospitals against their will if they're mentally ill and a potential danger to themselves or to other people, but we can't force them to treatment. That's a separate legal process altogether. In the article about people refusing treatment that seems to be an issue. The State wants the inmates to have treatment so they will be competent to be executed, but my concern is the larger issue about the consent to testing and the research that was done.

I wonder if you would talk about that. How was consent received from the prisoners?

DR. GELBORT: There's consent given each time someone is tested, but I think, in point of fact, the data becomes public record.

MS. BIENEN: The data become public record?

DR. GELBORT: Yes.

MR. CHAMBERS: How did the data become a public record?

DR. GELBORT: This material is all available in court proceedings.

MR. SANDERS: For example, when I filed Anthony Porter's petition, I put all the reports in the record. It's now in open court for everybody to see.

DR. GELBORT: You can get it online. Certainly through the Freedom of Information Act, you can get any of the court proceedings and most of the material ends up being read by third parties in some fashion.
MS. BIENEN: The court can close the record and the proceedings. In addition to ordering their own tests, the court can close a hearing.

JUDGE ANDERSEN: The court can close a hearing and seal court records, but a major principle of the American justice system is to do our business publicly. The first thing any dictator does is to conduct court proceedings privately so that the public is unaware of what is happening in courts.

The Supreme Court has said to judges that we should not readily seal files. There could be a strong public interest in seeing what’s happening. Nevertheless, under the right circumstances, information can be sealed by the court and, from a public standpoint, this may be the right thing to do.

CO-CHAIR GILL: That doesn’t satisfy the requirement for informed consent for research, and just because data is a public record doesn’t mean that it’s ethically exploitable by research.

DR. GELBORT: I think what happens is that you have people whose lives are at stake and who have a bigger issue on their minds than someone’s informed consent or research ethics. They’re interested in their story being told because it’s going to help them.

Now, there is an ethical consideration there in that this kind of puts a bind around them. On the one hand, they want the story told because it’s going to help them, but they are giving up rights as a result. I have not seen that contradiction resolved. Frankly, in all of the proceedings I’ve been involved in, I have never seen the record sealed.

MS. BIENEN: Are you aware of any attempt to do these kinds of tests for a whole death row population in a single state without identification of the individuals?

DR. GELBORT: No. Right now, to tell you the truth, with my data pool I think I probably have the largest data set. A couple of other neuropsychologists, if you are talking about neuropsychological data, are starting to get their data set out so research can be done. But there’s not been that kind of an attempt. Frankly, this stuff is relatively new. You go into the literature and it’s hard to find any sort of substantial study at all.

MS. BIENEN: Any additional comments?

MS. STANLEY: I just want to make a comment about the number of mentally ill within the correctional environment and also to mention a couple of hopefully important initiatives that are going on. More individuals are mentally ill in our jails than, unfortunately, are in our state psychiatric centers.

I was Chief of Service at one time at a psychiatric center. When we went to returning individuals to the community, we did not get support services in the community.
At the National Mental Health Association’s Conference there are a few places that are pulling together what we call “mental health courts,” where individuals who are accused of crimes, who are identified as having mental health difficulties similar to the drug courts, are able to go before a judge and attorney who have expertise, both in the law and in mental health. They work with the individual perhaps towards some alternative rather than going to jail, agreeing to try certain programs where you work with the staff in terms of medications and other things. Then, these individuals are followed. I know Florida has a few of these incentives going on.

The other thing that’s exciting is The Gaines Center. Gaines is a federal agency that specifically has money to help individuals who have mental health and substance abuse problems within the criminal justice system. One of the things that Gaines does is, if a community wants to do something about the number of individuals who are being placed in jail because of mental illness, help develop a working group of the police, health staff, mental health staff, lawyers, and so on, and judges. And they work out an intervention system, everything from teaching the police how to respond during a crisis to all the way up through the system.

Now these are some incentives that are working very well. There are others that are just starting. I think it’s important to recognize that there are individuals within the system who recognize all of these difficulties and who are trying different things. A forum such as this can bring the different fields together and let you know what’s happening in each one. I think it is really important to keep that dialogue going.

MS. BIENEN: I would like to turn in conclusion to the Chaplain, David Kyllo. Perhaps that’s a good place to end up.

MR. KYLLO: Most of the people who are on death row when they’re visited by a chaplain aren’t able to articulate a spiritual background or talk much about it. That may be part of the mental incompetency, not to be able to talk about spiritual attitudes or what’s going to happen to them after death. So they often report, as I have seen in religious journals or clergy journals, that people on death row can’t articulate what’s going to happen to them when they die. They’re not able to talk about their religious background, their foundations, or their faith and the types of things that are going on in their lives. That’s very interesting to me.

MR. SANDERS: I can add something to that. In one case in Arkansas when President Clinton was Governor, Rickie Ray Richter was given his last meal and did not eat his dessert. When asked why, he said, “I’m going to save it for afterwards.” I think that might express your point.

Anthony Porter, who grew up a Christian, in prison was both a Christian and a Muslim. I think largely to be with people, to belong, to get out of his cell. He got very, very upset when he didn’t receive lunch, so I don’t think
he understood what was happening there. He was following these views for other than religious reasons, which highlights his misunderstanding or his inability to understand.

And in response to what you said about personal responsibility, I'll give another example. As I described, I filed a lawsuit on behalf of Anthony Porter. I was then fired. He retained Johnny Cochran. Anthony Porter’s wish was that we all work together. I then heard him say that I refused to do this. This also highlights the cultural differences.

Talk radio had Johnny Cochran and James Montgomery as their guests and my partner, Eugene Pincham, and I were alerted that we should call in.

When I called in, I got Anthony Porter on the phone. I briefly asked his lawyers if we could all work together. That was the last thing I said to them. I asked them if they would relay that, and he gave me an answer that was not responding to my question. The next thing I know, he’s yelling at his new lawyer, saying there must be some kind of mistake here. It became clear to me this was all done without his awareness and without his control, even though it appeared that he was calling the shots. I think that’s been the story of his life.

CO-CHAIR GILL: I just want to bring this back to some of the earlier discussion. Kristi Kirschner and I note that at a number of points in this transcribed exchange, there is mention of research linking criminal violent behavior with brain injury or genetic predisposition. We realize that the idea of predicting violent behavior on the basis of an individual’s physiological characteristics is perceived by many critics as misdirected and potentially dangerous. Although, ideally, proponents believe such information could be used to improve environmental supports rather than targeting persons, we live in a far from ideal world. The possibility that such information could also be used to stigmatize, control, segregate, or otherwise maltreat targeted individuals must be taken seriously. History reminds us that society often finds its easier to scapegoat particular individuals then to take responsibility for difficult solutions. We hope nothing in this transcript will be misinterpreted as support for “easy” solutions. The relationship between human characteristics and crime is both complex and socially mediated. We are aware of and urge others to remain mindful of the critical role of environment in the oppressive, often violent, conditions that engender further violence.