THE MENTAL HEALTH EVALUATION IN CAPITAL CASES:
STANDARDS OF PRACTICE

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This article proposes standards of practice in mental health evaluations of capital cases. Without valid, reliable standards and criteria there is no adequate safeguard present to assure that the trier of fact will have the data needed to make an informed sentencing decision. The standard proposed is widely accepted as appropriate in standard mental health clinical evaluations, but is frequently not applied in capital cases. We propose that the following five steps should be used in all capital cases: 1) the collection of an accurate medical, developmental, psychological and social history, gathered from multiple sources; 2) a thorough physical and neurological examination; 3) a complete psychiatric and mental status examination; 4) diagnostic studies, including psychometrically based approaches to personality assessment, neuropsychological testing, appropriate brain scans, and blood tests or genetic studies; 5) the use of other specific specialists and additional appropriate tests as indicated. This article concludes with an edited sample declaration done by Dr. Foster for a defense appeal on a death row inmate convicted of murdering a girlfriend and her three children. The declaration illustrates how these five steps can form the basis for designing the more specific composition demanded in any capital case evaluation to ensure thoroughness and acceptable limits of reliability and validity.

In this article we seek to address the failure of the judicial system to specify appropriate standards for mental health evaluations in capital cases. This concern arises from our involvement as evaluators and consultants in capital cases and the appeals process for prisoners on death row.

In California there are nearly 400 inmates on San Quentin's death row and many more in the pipeline. Each of these cases costs the state an aver-
age of $2,000,000 to $6,000,000 for the appeals process alone. Thus, conservatively, nearly $800,000,000 will be spent by the state on those currently convicted. Much of this money is spent on expert witnesses and accompanying legal fees or time and resources taken from the State Public Defender’s and Attorney General’s Office. These evaluations could be more efficiently done at the time of trial, reducing the numbers who receive the death penalty, and significantly shorten the appeals process, and thus the cost. It also can be argued that if these resources are made available for use in early identification, intervention and prevention among children with similar early developmental and psychosocial difficulties, the number of capital crimes committed may diminish.

As early as 1972 the U.S. Supreme Court began to provide clear substantive policy and criteria for imposition of the death penalty (1). Since 1976, when the U.S. Supreme Court upheld death as punishment, courts have consistently found that death sentences may be imposed only if the sentencing proceeding is reliable, fair, and free of arbitrariness. Defendants in capital cases have a right to consideration of any and all mitigating circumstances that offer insight into the "frailties of humankind" and "the character and record of the individual offender" (2). The U.S. Supreme Court upheld statutes identifying aggravating and/or mitigating circumstances to consider prior to sentencing (3). The Court went further in requiring the decision maker to consider all relevant mitigating evidence concerning the defendant (4). State and federal courts have continued to develop a body of law that gives guidance about what factors constitute mitigation. While specific aggravating and mitigating mental health factors tend to vary by jurisdiction, they include a history of chronic child abuse and maltreatment, mental retardation, schizophrenia and other psychoses, organic brain damage, emotional disturbance, depression, posttraumatic stress disorder, alcoholism, drug dependency, and other emotional disturbances.

In addition to sentencing considerations, there are a number of other junctures where mental health evaluations are often considered. These include sanity at the time of the offense, competency to stand trial, the va-
lidity of prior convictions for offenses used as a basis for seeking death sentences, diminished capacity, duress, domination by others, ability to premeditate and intend death, competency to be executed, voluntariness of confessions, the competency to comprehend *Miranda* rights, and the reliability of confessions, even if they were freely and voluntarily given. Psychiatrists and psychologists are often called upon to review the reliability of previous psychiatric evaluations and offer their opinions on whether the standard of practice was met.

In each of these situations there are specific elements of a competent and reliable mental health evaluation which reflect a standard of practice that has evolved over the years since the death penalty was held to be constitutional. The standard of practice today requires psychiatrists and psychologists to be able to address a range of complex psycholegal issues that demand specialized expertise, care and consideration. The standard of practice is the national criterion recognized among similar specialists rather than a local, community based standard of practice.

The national standard of practice in psychiatry and psychology regarding clinical evaluations demands sensitivity not only to the questions asked, but the context as well. This focus on conceptual validity as described by Maloney and Ward (5), while necessary in any clinical evaluation, may be of paramount importance when evaluating the defendant in a capital case, due to the responsibility the evaluator has to synthesize and integrate a lifetime of relevant history, behavior and psychological status to convey to the trier of fact. The model proposed is the minimal standard which any judge hearing a capital case must insist on prior to trial. Given the finality of the death penalty, the need for objective standards with acceptable levels of reliability and validity are crucial.

In our judicial system, the sentencing judge or jury is required to assess the seriousness of the crime committed, the harm done and the culpability of the offender. The issue of culpability is especially sensitive within the potential context of the death penalty. Without valid, reliable standards and criteria there is no adequate safeguard present to assure that the trier of fact will have the data needed to make an informed sentencing
decision. If the critical elements of a mental health evaluation are not present, then the judge must not allow the case to be heard until all elements have been completed. While the literature has historically lacked a specific standard of practice for mental health evaluations in capital cases, there is a rich history of an evolving underlying standard in general mental health clinical evaluation. For example, a widely accepted reference, Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* makes specific suggestions (6). This skeletal structure can form the basis of designing the more specific composition demanded in any capital case evaluation to ensure thoroughness and acceptable limits of reliability and validity. In capital cases this includes:

- an accurate medical, developmental, psychological and social history. Historical biopsychosocial data must be obtained not only from the accused, but from independent and multiple sources to provide an adequate data base of convergent validity.

- a thorough physical and neurological examination.

- a complete psychiatric and mental status examination.

- diagnostic studies, including psychometrically based approaches to personality assessment, neuropsychological testing, appropriate brain scans, and blood tests or genetic studies. It is highly unusual that collateral procedures will not be mandated by the clinical data.

- specific specialists and additional appropriate tests, such as experts in mental retardation, endocrinology, or toxicology, as indicated.

**HISTORY**

An adequate social, developmental and medical history is the crucial first step in a mental health evaluation in a capital case. An accurate and broad based history has been called the "single most valuable element to help the clinician reach an accurate diagnosis" (6). Staub and Black in their text on organic brain disorders state it "is often only from the details in the
history that organic disease may be accurately differentiated from functional disorders or from atypical lifelong patterns of behavior" (7).

The typical adult psychiatrist or psychologist may not be as effective nor as cost efficient at identifying the social and developmental history as a specialist, such as a trained social worker or mitigation specialist who is capable of investigating and documenting factors that affect development and functioning. There is legal precedent documenting a number of mitigating factors including psychological and physical abuse, maltreatment, sexual abuse, genetic heritage, physical illnesses with psychiatric consequences, neurological conditions, physical trauma, prenatal exposure to toxins, alcohol and chemical abuse and dependency. Reliable documents should be gathered, including birth and school records, previous psychiatric evaluations, criminal and civil judicial proceedings involving significant family members, and medical, social service and military records.

Interviews with family members, neighbors, classmates, teachers, employers, friends, acquaintances, probation officers, and previous attorneys should be conducted to determine the offender's level of adaptive functioning, cycles of behavior, and trauma not identified in written documents by institutions.

Only after a social and developmental history has been provided and reviewed, is it appropriate to determine the kinds of diagnostic tests to administer and the types of other professionals to collaterally involve in the assessment. As previously noted, it is frequently the case that a psychiatrist or psychologist alone is not qualified to offer a diagnosis, for example, in the case of a mentally retarded or neurologically impaired defendant. In some cases, unique cultural considerations require the assistance of experts familiar with the nuances of the culture and its potential influence on individual behavior.

It must be emphasized that the historical data must be obtained not only from the patient, but from sources independent of the patient, since it is well recognized that the patient is often an unreliable and incomplete data source for his or her own medical, social and developmental history. As Kaplan and Sadock state, "The past personal history is somewhat dis-
torted by the patient's memory of events and by knowledge that the patient obtained from family members" (6, 8). Accordingly, "retrospective falsification, in which the patient changes the reporting of past events or is selective in what is able to be remembered, is a constant hazard of which the psychiatrist must be aware" (6). Because of this hazard,

"It is impossible to base a reliable constructive or predictive opinion solely on an interview with the subject. The thorough forensic clinician seeks out additional information on the alleged offense and data on the subject's previous antisocial behavior, together with general "historical" information on the defendant, relevant medical and psychiatric history, and pertinent information in the clinical and criminological literature. To verify what the defendant tells him about these subjects and to obtain information unknown to the defendant, the clinician must consult, and rely upon, sources other than the defendant (9).

It is well established that the greater inflow of data increases the reliability of the outcome of a forensic opinion (8).

Family history, biological, genetic, developmental, and environmental factors that have bearing on the defendant's behavior and mental state when the crime was committed and throughout the legal process are often first identified in the process of collecting an accurate biopsychosocial history.

**PHYSICAL/NEUROLOGICAL EXAMINATION**

The second step is a thorough physical and neurological examination. In reviewing evaluations previously done and comparing them to later physical and neurological evaluations by physicians trained to look carefully for signs of abuse (for example, scars and bone deformities), subtle neurological "soft" signs (and sometimes glaring signs), and endocrine abnormalities, we found that many of the less obvious physical and neurological findings had been overlooked or missed. Such physical findings can confirm historical data, or lead to questioning of the subject or wit-
nesses that may provide more details required to establish or challenge a history of alleged abuse, head injury or metabolic abnormalities. Thus, examiners should be chosen who have expertise at identifying evidence of abuse, soft neurological signs, and endocrine or metabolic disorders.

MENTAL STATUS EXAMINATION

The third step, a mental status examination, seems obvious, but the number of times it is overlooked at crucial junctures in the legal process when it could have critical bearing in the outcome is sometimes appalling. For example, SA, a 32-year-old black male, was arrested for the murder of a woman waiting in line at a drive-through bank teller. Witnesses described his behavior before the shooting as bizarre. Just after he was arrested, he lacerated his head and was sutured by an emergency room doctor. Medical records indicate he seemed preoccupied with internal stimuli and that his eyes were moving rapidly from side to side and that there was a wide gap between his systolic and diastolic blood pressures (These are common symptoms of phencyclidine [P.C.P., angel dust] poisoning with an altered mental state). Neither psychiatric evaluation nor urine and drug screens were obtained at the time. Much later, while awaiting trial, he became violent in prison and required solitary confinement, where he continued to show bizarre behavior. At the time of his trial and again at the time of his sentencing, transcripts of his testimony evidence difficulty tracking the proceedings and loosening of associations in his thought processes. All of these would have been essential times for mental status examination to help determine the issue of competence and better understand his ability, or lack of, at that time to cooperate in his defense.

It is well known that many psychotic states are improved when the subject is in a highly structured, predictable environment with limited stimulation. Our experience is that some of the more profoundly disturbed mentally and/or organically impaired subjects have actually improved after time on death row, perhaps as a result of the highly structured, predictable environment, often with limited and controllable levels of stimu-
lation. Current clinical findings must therefore be compared with historical levels of functioning and hypotheses offered to explain the differences.

Testing for organic factors on the MSE as part of the overall assessment includes, of course, the standard questions of orientation, memory, calculations, and abstraction. However, it has been our experience that this gross screening procedure is not enough. Even in the absence of overt data, other collateral psychometric measures such as the Bender-Gestalt, the Trail Making Test or the Screening Test for the Luria-Nebraska Neuropsychological Test Battery should be utilized to provide greater diagnostic precision. In keeping with the commitment to a higher standard of specificity demanded by the context of the evaluation, we suggest for example, that when assessing for ADHD, aside from the standard digit spans, and observing for evidence of distractibility and impulsivity, the evaluation can be enhanced by using continuous performance tasks. For example, even if not pursuing a formal psychometric approach initially, using the writing of dictated phrases will sometimes elicit language processing problems not evident on cursory examination.

While it is sometimes difficult to find objective evidence of PTSD, apart from history, after a rapport has been established, it is sometimes possible to use the history, obtained from witnesses, of the abuse to confront the massive denial projection, splitting, dissociation, and repression which are often present. This is especially difficult because many of the death row inmates are so heavily defended; in part because of the intense disorganizing effect such memories have on them; in part because they have been conditioned to deny their vulnerabilities and fears in order to survive their backgrounds and prison life and in part due to their organic deficits. This difficulty is compounded by the finding that most death row inmates we have interviewed would rather die than be diagnosed as psychiatrically impaired, or "weak." A possible way through these defenses is intensive consecutive day interviewing. On consecutive day interviews we have found the inmates coming back quite upset about how unraveled they became in the interim, or the nightmares they experienced. The interviewer seeks to remain empathetically connected, while stressing the in-
mate enough to penetrate the defenses, so that a picture might be obtained of the mental state. Without the opportunity for consecutive intensive interviewing, it is less likely that these important symptoms will be uncovered.

Because of this typical defensive strategy, it is unlikely that the direct questions of structured interviews will yield an entirely accurate picture. Nonetheless, structured diagnostic interviews can be helpful as guides to assist the examiner in exploring all appropriate potential diagnostic possibilities and in overcoming the inherent methodologic problems intrinsic in the "clinical interview" (for an exhaustive review, see Ziskin [10], pp. 159-200). But our experience suggests this structure must be coupled with follow-up questions, and open ended inquiries that attempt to minimize or circumvent defenses. Asking about dreams and nightmares, for example, can be couched in questions about sleep disturbances, along with normalizing statements like, "Most people have nightmares or bad dreams on occasion. Tell me about some of your dreams." This can then lead into asking about hallucinations by asking about "dreams when you are awake. Not daydreams but hearing and seeing things like in a dream but when you are awake." Or, "Most people when they are alone or really stressed or tired have their minds play tricks on them. Tell me what happens to you when this happens."

NEUROPSYCHOLOGICAL AND PERSONALITY ASSESSMENT DATA

Since there is such a high incidence of neurological and psychiatric impairment combined with a history of having been abused and molested in the violent population (11), it is rare that an honest and thorough evaluation reveals a complete paucity of data. Nonetheless, there are murderers who do not have any of these findings. However, given the high incidence of organic and developmental compromise found in this population, the fourth step includes the collection of neuropsychological and personality assessment data. This evidence assists with quantifiable objective findings to assist in differential diagnosis. The neuropsychological approach offers a unique perspective on brain-behavior relationships, thus adding greater
diagnostic precision as to whether the defendant's behavioral symptoms may have some anatomic basis. Through psychometrically reliable and valid measures, deficiencies in intellect, emotionality and control, which manifest as the result of organic compromise, may be identified. By assessing personality variables psychometrically, the psychologist is able to provide a description of the individual's emotional life and character structure, which meets the basic criteria of interdiagnostic agreement, adequate descriptive breadth, descriptive validity, predictive validity and reliability. Thus, through the collateral use of appropriate and traditional methods of neuropsychological and personality assessment measures, convergent or divergent data is identified to assist in the understanding of the individual offender.

**OTHER SPECIALIST AND ADDITIONAL APPROPRIATE TESTING**

The fifth step is included so that specific experts will not be overlooked when information is uncovered that requires their expertise. Recognizing one's limits and the need for other specific experts can, at times, be crucial. A recent example was the discovery that one death row inmate had severe neuropsychiatric and cognitive deficits in the context of finding that his mother, a migrant farm worker, was exposed to high levels of specific pesticides during pregnancy. A toxicologist was able to describe the specific neurotoxic effects of this pesticide on the developing fetus and thus establish the longstanding nature of this previously missed mitigating factor. In another case there was suspicion of phencyclidine (PCP, Angel Dust) poisoning in the defendant at the time of the crime but no drug testing had been done. An expert in drug effects was asked to evaluate the records. A careful evaluation of an emergency room visit for suturing a laceration shortly after his arrest on the day of the bizarre murder, uncovered nursing notes that documented an abnormally wide difference between systolic and diastolic blood pressure and abnormal eye movements consistent with nystagmus. Both of these signs are classic symptoms consistent with PCP poisoning to which the expert could testify.
Following these five steps increases the likelihood that the trier of fact will have the data needed to make an informed sentencing decision. Nonetheless, the synthesis of this data so that its relevance to the case is clear can be a challenging task. What follows is an example of a declaration dealing with these five steps in presenting issues relevant to mitigation. A declaration is a sworn statement by an expert on facts and opinions relevant to the case. In this case the expert was asked to do a psychiatric evaluation and integrate it with all relevant mental health issues in the case. The following sample declaration is a synthetic attempt to weave the above five steps into a coherent fabric. In this edited and redacted version of the declaration, the names and locations have been changed to protect confidentiality. This particular case was chosen because of the number of mitigating factors overlooked in the initial evaluations. These oversights were, in our opinion, due to the fact that these evaluations omitted the steps proposed in this protocol. Although the case may appear extreme, it is our experience in death row cases that many, if not all, of these mitigating factors may be present. But the opposite may be true; we have also performed evaluations where very little developmental trauma, neurological damage or psychiatric illness is discovered. The following declaration is presented not because it fully measures up to the standard, but as an example of how one might get a start at applying the standard in the trying and rewarding job of synthesizing the multiple steps. Note the bias in this declaration toward psychological trauma and dissociation versus other important mitigating findings. As you read consider other ways the data might be synthesized to more accurately communicate the complexities of this case.

DECLARATION OF DAVID VERNON FOSTER, M.D.

I, David Vernon Foster, M.D., hereby declare under penalty of perjury as follows:

[The first few paragraphs of the declaration describe relevant aspects of the writer's curriculum vitae that establish his credentials and qualifications. For example, "I am a physician licensed to practice in the states of...I have been a Diplomate of the American Board of Psychiatry and Neurology since..., etc."

At the request of counsel for Dan Jones, I conducted a psychiatric examination of Mr. Jones at Walla Walla State Penitentiary over a two day period on July 1 and 2, 1992.
The purpose of my interview was to determine Mr. Jones' mental status currently and at the time of the offenses for which he has been sentenced to death; the factors that influenced his development and functioning; the reliability of statements he gave to law enforcement officers; his ability to aid and assist counsel and to understand rationally and factually the proceedings against him; his competency to testify; his ability to make knowing and intelligent waivers of his rights including his right to counsel, to trial, to the confrontation and cross-examination of witnesses; and the presence, severity and effect of child abuse.

The examination included a mental status examination, a structured psychiatric diagnostic interview, and lengthy open-ended interview designed to assist in eliciting contradictions and evidence of malingering and falsification. I also reviewed extensive documentation of his family and social history, his developmental history, educational records, and multiple psychiatric and psychological evaluations and reports, as well as medical records and neurological evaluations. Of particular note are the neurological findings of ______, M.D., and the neuropsychological findings of ______, Ph.D. The materials I reviewed included a summary of Mr. Jones' substance abuse history, documents pertaining to Mr. Jones' family mental health history, declarations from family members, medical and psychiatric records, neuropsychological testing data and results, neurologic examination results, materials pertaining to Mr. Jones' prior convictions, declarations from other mental health professionals, transcripts of Mr. Jones' interrogations by sheriff's department personnel, and testimony relating to those interrogations. Additionally, I reviewed a detailed life chronology of Mr. Jones and his family. These are the kinds of materials routinely relied upon by experts in the field of psychiatry to reach a medical opinion.

**SUMMARY OF FINDINGS**

A full and accurate assessment of Dan Jones' psychiatric and neurologic condition requires thorough review of biological, genetic, and environmental factors that influenced his development in infancy, childhood, adolescence and adulthood. Mr. Jones was at risk at each of these stages. Even prior to conception, Mr. Jones was likely genetically predisposed to mental illness. His father was a delusional, paranoid, alcoholic with manic and depressive symptoms consistent with a diagnosis of bipolar II disorder or with organic affective illness. His mother was reported to be an alcoholic, drug abusing prostitute with psychotic symptoms and a diagnosis of schizophrenia. His grandfather, once arrested for child molesting, lived isolated in a shack in the hills. Furthermore, Mr. Jones' neurological foundation was likely poisoned while still in his mother's womb. In utero, Mr. Jones was exposed to toxins as his mother reportedly drank heavily daily during his gestation. Heavy drinking during pregnancy is a known cause of brain and behavior disorders, including disorders that effect cognitive ability, attention, impulsivity, judgment, planning, and organizational skills. Likely predisposed to mental illness and brain damaged in utero, Mr. Jones was abandoned by his biological parents shortly after his birth and sent to live with his brothers on an unlicensed foster farm. There, his early life was one filled with torture, repeated and life threatening physical assault, sexual abuse, and chronic trauma. He suffered severe and multiple insults to his brain, including direct trauma, pro-
longed instances of anoxia, and exposure to toxins including glue sniffing and chewing tar. On the farm, Dan Jones was tortured physically, sexually, and psychologically, and was forced to participate in the torture of animals. At an early age, he learned to use codeine, glue and other substances to medicate away his emotional response to the multiple traumas to which he was subjected.

Mr. Jones’ school records provide early indications of neurologic impairment. He exhibited attentional problems, an inability to learn math, signs of organic brain damage, and symptoms of depression. Social factors can have a profound effect on development, and Mr. Jones’ environment prohibited the development of an emotional or cognitive ability to cope.

At the age of nine, Mr. Jones was reunited with his alcoholic, abusive, biological father who provided him with a chaotic and desperate life of hunger and instability. The next several years offered only more chaos and abuse, including separation from his brothers, placement in several foster homes, juvenile hall when no homes were available, the Department of Juvenile Rehabilitation, and finally, prison. As an adult, Mr. Jones continued to use illicit substances to self medicate the effects of neurological impairments, abuse, and trauma.

Mr. Jones suffers from severe mental, psychiatric, neurologic, and developmental impairments which are multifactorial and significantly compromise his ability to function normally. Mr. Jones suffers from organic brain damage, neurologic and developmental deficits, and post-traumatic stress disorder. Mr. Jones has periods of dissociation during which he is not conscious of his actions and has no awareness of them. He has serious memory deficits and the neurologic symptom of confabulation to fill the gaps in his memory. Thus, when a dissociative state is triggered his actions are uncontrolled and uncontrollable and he often has no memory of them.

[The following incorporates materials collected for step one. These include multiple medical, school, and social agency records as well as sworn declarations of family members and witnesses to family history and childhood events described below.]

BIRTH FAMILY

A competent, reliable evaluation of Mr. Jones’ disabilities must consider Mr. Jones’ family history of mental illness, organic disabilities, and substance abuse. There is very strong evidence that certain mental, emotional, and organically based brain disorders like manic-depressive illness, addictive illnesses, schizophrenia, certain anxiety disorders and certain brain conditions affecting attention and impulsivity are genetically transmitted. Medical diseases and disorders such, hypo- and hyperthyroidism, hypertension, cystic malformations and systemic illnesses may also have psychiatric consequences and may have a genetic component. Therefore, it is important to consider the mental and physical health of Mr. Jones’ parents, siblings and child.

Mr. Jones’ father, Robert Jones, was diagnosed with severe psychiatric problems as early as his twenties. [The declaration goes on to cite multiple records that document severe psychiatric impairments that include psychotic symptoms, bipolar illness, and alcoholism. These findings help to establish a possible genetic link to some of the inmate’s abnormal behaviors.]
Dan Jones' mother suffered from addictive illness and eventually died of cirrhosis of the liver. Court records show that she was considered emotionally disturbed, unstable, and schizophrenic. She attempted suicide at least once.

Each of Mr. Jones' siblings has an addictive illness and a troubled history. At least one seriously attempted suicide. [Descriptions of documented disorders in each of the brothers are remarkably similar to the disorders found in the defendant, including findings consistent with in utero exposure to alcohol, brain dysfunction, specific cognitive and memory impairments, seizures, post-traumatic stress disorder, major depression, psychotic symptoms diagnosed as schizophrenia, mixed substance abuse, and other social and behavioral dysfunctions. The oldest brother attested to the special scapegoating and the extreme severity of the abuse to which Mr. Jones was subjected.]

Dan Jones fathered one child, Rita Morales, who was born July 23, 1964. She is now in her twenties. Hospital records indicate that Rita suffers from hypertension, onset age 13, hypothyroidism, systemic lupus erythematosus, and obesity. She is also reported to have severe emotional disabilities, engages in repetitive behavior and perseveration. She has a short attention span and low frustration tolerance. An MRI conducted in 1991 indicated evidence of brain abnormalities, and an EEG showed abnormalities consistent with lesions in the left anterior temporal area. [Thus a multigenerational pattern of brain and psychiatric disorders is established, strengthening the case for genetically based disorders in Mr. Jones.]

**CHILDHOOD**

Mr. Jones was abandoned by his parents shortly after his birth. He was sent to live on an unlicensed foster farm in rural Longview, Washington. On the farm, which was run by Ruby Bradford, Mr. Jones was tortured and chronically abused physically, sexually and psychologically, and forced to participate in the torture of farm animals. The abuse was unpredictable in nature and was carried out by his caretaker, Ruby Bradford, her husband Benjamin, and their two adult children, Harold and Melanie. [The declaration goes on to catalogue the specifics of the horrendous abuse, molest, injury, anoxia, and head trauma to which Mr. Jones was subjected as a child. Also present in the declaration is an elaboration of school records which document his learning disabilities and give descriptions consistent with severe emotional disabilities which were never adequately addressed by the school. Although valuable as an example of exemplary psychosocial research on the part of the legal team, space does not permit its replication here. A synthesizing declaration such as this is very dependent on the quality of the psychosocial information gathered. In this case, much credit goes to both the lawyer, who supervised the process, and the assembler of the psychosocial history who went out and found the records and obtained the declarations of his older brothers and other witnesses.]

**ADOLESCENCE**

Records indicate that Dan Jones suffered serious depression, attentional deficits and other neuropsychological deficits, and trauma, throughout adolescence. [The declaration then goes on to document in detail the evidence for and severity of these conditions, and the damage caused by at least twelve different placements during his adolescence.]
In spite of his difficulties, records consistently showed that Dan tried his best, was cooperative, and "was willing to help in all ways except studies." Dan was reportedly quite respectful to adult authority, had good peer-relationships, got along well with the other boys, and showed respect for the rights of others. These factors are all inconsistent with the diagnosis of Anti-Social Personality Disorder (ASPD).

Dan Jones' remaining history is one of incarceration punctuated by periods of very dysfunctional behaviors as he attempted to survive in noninstitutional settings. Between 1960 and 1970 he was under the jurisdiction of the Department of Juvenile Rehabilitation (D.J.R.) where he completed high school at the age of 19.

ADULT CRIMINAL AND PRISON HISTORY

In July of 1971, Dan was arrested for kidnapping and molesting a nine-year-old girl whom he did not know. According to a psychiatric report at the time, Dan reported drinking "at least six quarts of beer a day and taking about thirty mini-whites [amphetamine] a day." He reported no memory of the crime, had a flat affect and a vacant expression when interviewed regarding it. He was convicted and sent to a program for convicted sex offenders at McNeil Island State Prison, where he stayed from January 31, 1972 to June 30, 1974. Prison records from that period note his feelings of guilt, his impulsivity, and confusion, fear and anxiousness toward women.

On release from McNeil Island, he reportedly established a one year relationship with an adult woman who met his sexual needs. He was convicted February 3, 1976 for two offenses committed in 1975 during which time he was reportedly ingesting large quantities of amphetamines, and hearing voices and having hallucinations. Again, he was unable to recall the event and records describe his actions as having a "psychotic quality" and that he had "no awareness of them." He was admitted to the State Prison at Shelton, Washington, on May 15, 1976 and released in 1980. His diagnosis at Shelton included schizoid personality. His depression and deficits continued.

In 1980 he was minimally employed, working and living at a wrecking yard. He referred to himself as socially retarded, had no support system and no family, had difficulty with impulse control, reported loneliness and boredom. In 1981, he was readmitted to the Department of Corrections on a kidnap charge of which he had no memory. When arrested he was intoxicated. In 1986, he told a prison medical officer, Dr. ________, that he was not ready for release and "needed more help."

Mr. Jones was released in February 1986, and was again ill equipped to cope; he had no job or job skills, no transportation, no family or friends. He again began taking amphetamines and on the evening of Saturday, April 4, 1986, was reported by peers as appearing psychotic, speaking in riddles, and appearing fidgety and red-eyed. The night of his arrest, April 7, 1986, Mr. Jones was again exhibiting signs of psychosis. He claimed to be on a mission to rescue a woman and her children who, he stated, were being forced by their father, a suspended police officer, to make pornographic movies, and he claimed to have a supercharged car. It was shortly after this that he was arrested, interrogated at considerable length, and, although he cannot remember committing the crimes, he confessed to the brutal murder of the woman with whom he was staying and sharing drugs, and to the murder of her three children.
MEDICAL HISTORY

[A description of the medical history and previous medical and neurological evaluations is a segue into Step Two. Enumerated in this declaration are his history of multiple very severe head injuries, near drowning with prolonged anoxia, subsequent severe headaches, and gaps in his medical evaluations (EEG, Appropriate brain scans, etc.)

Other medical problems such as eye problems, recurrent tonsillitis, hives, cysts, and chronic lymphatic pathology are enumerated. Although the relevance of these conditions for this case is not obvious, there may be some future sense made of these findings. They are, therefore, included in the declaration for the purpose of keeping possibly relevant data in the court records and future options open. This may also be the place to consult with specialist (Step Five) in relevant areas—for example, in autoimmune disorders and endocrinology. A more complete description of fetal alcohol syndrome and effect and the evidence for its presence in the prisoner and his brother are also provided here. Documented also were the multiple substances and toxins to which he was exposed in his childhood and youth.]

PREVIOUS PSYCHIATRIC AND PSYCHOLOGICAL EVALUATIONS

Available psychiatric and psychological evaluations offer evidence of Dan's organic brain damage, neurological impairment, and emotional trauma. Comments by teachers, social workers and probation officers who had contact with Mr. Jones in his preadolescent years indicate that his impairments are long standing. He suffered from a short attention span, restlessness, depression, anxiety, insecurity and immaturity. [What followed in the full declaration was a summary of all previous relevant evaluations. For example, there was significant material from juvenile hall and prison evaluations done by various psychologists and psychiatrists that established a long history of cognitive impairments hyperactivity and impulsivity, impaired judgment and insight, physical incoordination, memory impairments and other evidence of neuropsychological deficits, and lack of internal controls. These reports were consistent with more recent neuropsychological and neurological evaluations that documented attentional and memory deficits, organizational and planning deficits, problems with cognitive flexibility and strategic thinking, and difficulty with auditory tracking, and a tendency to confabulate (Step Four). Significant depression and apathy were usually found and sometimes treated with antidepressants. When he was arrested for child molestation a psychiatric evaluator found him to have "psychotic qualities" and to have "recourse to a child sex object in a mood of confusion and frenzy." Other symptoms consistent with a dissociative disorder and PTSD were also described.]

[Since antisocial personality disorder is sometimes used as a garbage pail screen to hide a failure to do a careful and thorough evaluation, it is often important to discuss the evidence for and against this diagnosis. In the declaration this was done in some detail and summarized as follows.] The ASPD diagnosis is often proffered when a psychiatrist has no other explanation. The diagnosis does not take into account Mr. Jones' neurological damage, post-traumatic stress disorder, or trauma. Finally, the diagnoses ignore early behavior which is inconsistent with antisocial personality disorder. Records from his ado-
lescence consistently showed that Mr. Jones tried his best, was cooperative, was willing to help, showed respect to authority, had good peer relationships, got along well with the other boys at juvenile facilities, and showed respect for the rights of others.

[Deleted here are a more detailed description of the most recent neuropsychological and neurological findings consistent with the above descriptions (Step Four).]

PSYCHIATRIC INTERVIEW

Mr. Jones was an initially guarded, but alert, oriented, and cooperative 45-year-old greying white male, appearing older than his stated age. He is approximately five feet five and one-half inches tall and reports feeling self-conscious about his size. He appeared very tense. He had a great deal of difficulty identifying and verbalizing feelings. He has close set eyes, with a one inch scar at the hairline. Closer examination of the skull revealed a mid sagittal scar about two inches in length at the apex (corresponding to a history of having been struck by an ax as a child), and behind this scar and slightly to the left of midline, a one inch scar (corresponding to a history of having been hit by a tire iron as a young adult). He has a vertical scar on his right ear lobe. He has short stubby fingers with scars on his knuckles, and thumb (corresponding to reports of self injury such as hitting walls in juvenile hall). Further scars were noted on the right forearm near the wrist and a horizontal scar on the dorsal left wrist, and on both ankles and left foot (consistent with reports by his brothers of his having been bound as a child by his foster mother and foster brother), many small puncture wound scars on his back and left flank, the origins of which are unknown to him (but which are consistent with reports by his brothers of having seen him repeatedly beaten to the point of bleeding with the belt buckle end of a belt, and with the subject's vague memories of a brass belt buckle coming down at him). [This detail in looking for corroborating evidence of abuse and trauma in Step Two is not common in physical and neurological exams. Therefore it is helpful to request that the physician look for and describe such findings if they are present.]

He admitted difficulties with his memory and was unable to remember five digits backward (impaired immediate memory), could not remember three items for five minutes (impaired recent memory), and could not remember events from his past that are well documented by others (impaired remote memory).

Mr. Jones' thought processes were at times tangential and circumstantial, and at times showed loosening of associations when left unstructured in his responses. The former is an indicator of organic impairment and the latter of psychotic thinking. These thought disorders were also noted by the neurologist, Dr. ______. [Pointing out convergence of data in Step Three with data from Step Four.]

Mr. Jones appears to experience episodes of dissociation. A dissociative state results in the loss of contact with reality from brief periods of a few minutes to much more prolonged periods of time. Dissociation can be triggered by the intrusion of memories of past traumatic events, or current events which remind one of past traumas and trigger automatic dissociative reactions. These states are common in individuals who have experienced trauma at a young age. Mr. Jones describes multiple examples of dissociative episodes when an event occurred or someone said something that caused him to feel threatened. He reports that he "sees red," loses consciousness of what happens and comes
to consciousness at some later time to find that he has done something of which he was not aware. The triggers to these episodes were likely borne out of the abuse and abandonment he suffered as a child. One trigger is the threat of abandonment, and another is a threat of physical harm to him or someone he perceives as being preyed upon by someone stronger, more powerful, and dangerous. An example of the first was being locked in juvenile hall and feeling utterly abandoned. He remembers the terror of abandonment, a period of disorientation, and then no memory until he was being restrained with his hands bloodied from pounding on the cinder block walls. An example of the second was when he found a woman he loved "more than anyone I have loved" sexually involved with another woman. He remembered the terror of losing her. But he remembered nothing after finding them together until he came to in another room with his hands in shreds and bleeding from beating on a heater grate. "The pain would bring me back to reality." After this he went on a three day amphetamine binge and ended up committing the sexual offense for which he was first convicted. The subsequent offenses were likewise committed in drugged and altered states and for which he consistently reported no memory of the events. Additionally, records note that before the events in 1975 he had been hearing voices and hallucinating. He has no reliable memory of his actions while physically present at the residence where the murders took place. He describes coming to his senses later, panicked and in a fog. All of the foregoing factors support the interpretation that Mr. Jones was in a dissociative state or blackout at the time of the offenses for which he is currently convicted.

He demonstrated symptoms of dissociation during my interview of him. He experienced two episodes where he "spaced out" when we were talking about emotionally laden material and could not recall what we were talking about. During the dissociative state, Mr. Jones was incapable of knowing or understanding the nature and quality of his actions and therefore could not conform his conduct to the requirements of the law. His memory is fragmented and any reconstruction of the dissociated events is wholly unreliable.

As commonly present in persons with temporal lobe dysfunctions, Mr. Jones is preoccupied with finding connecting patterns and meanings that he has a feeling he has found but then loses. At times the logical train of his thought was interrupted and his associations became loose and his thought content became increasingly bizarre. For example, at one point we were discussing previous treatments and he associated to a therapist who believed in "astral projection" (the ability to project one's consciousness outside of the body). He became increasingly loose and nonsensical as he attempted to explain this concept.

Mr. Jones minimized his depressed mood, but remembered feeling suicidal from the age of 10. Early records indicate his depression has been long standing. He reports: "I don't think I was ever happy." He remains very despondent and has said, "I have trouble with me being here [alive] and others not. He adds, "They will be doing me a favor when they execute me...I disgust myself." He explained that "The only reason I talk with you guys is the hope that someone might make sense of what I have done so someone else might benefit." At other times he reported that his mood has been expansive and grandiose, "but I've never been really happy." Jail records from 1986 and 1987 indicate
that Mr. Jones' depression continued after his arrest and during the trial, and that it went untreated. Mr. Jones reports that he was self-medicating his depression with high doses of Elavil while awaiting trial. He got this medicine from a fellow inmate and reports taking handfuls and feeling in a daze. If this is true he would likely have been sedated, his thinking would have been clouded, and his memory impairments would have been amplified, depending upon the quantities he was consuming. This would have further compromised his already severely impaired cognition. When prescribed, quantities are built up slowly and monitored to avoid these side effects.

Serious neurologic deficits were noted in my examination of Mr. Jones. In addition to finding choreoathetotic movements and difficulties with rapid alternating movements and concrete thinking also reported by Dr. _______, the neuropsychologist, I found that Mr. Jones demonstrated severe deficits when asked to generate a wish and translate it into writing, a task which requires several areas of the brain to function simultaneously. Mr. Jones could verbalize the material but became paralyzed in his ability to translate it to writing. He is left handed and when struggling to complete the task he became very tense and his left cheek began to twitch. He reported that he knew what he wanted to do but then lost his train of thought. His focus became unclear and he broke out in a sweat as he struggled to complete the task. Embarrassed, he then refused to continue. He was finally able to complete the task when his verbal production was slowly dictated back to him.

Research in brain-behavior relationships indicates that the conscious generation of desires is organized in the medial prefrontal and frontal lobe of the dominant hemisphere (usually the right hemisphere in a left handed person) and is then monitored and edited in the nondominant prefrontal and frontal lobe (usually the left in a left handed person). Planning and execution are initiated in the dominant lateral prefrontal and frontal lobe. Verbal translation utilizes the dominant temporal lobe and motor production of writing utilizes the dominant parietal lobe. Mr. Jones' problems with this task confirm the neuropsychological findings of Dr. _______. Mr. Jones has severe problems with frontal lobe functions of planning, evaluation, and modulation and has impairments in the frontal-temporal connections necessary for verbal planning and the use of verbal thought to modulate impulses.

CONCLUSIONS

It is my professional opinion which I hold to a reasonable degree of scientific certainty that Mr. Jones suffers from post-traumatic stress disorder and organic brain damage. His deficits include a combination of psychiatric, neurological, and developmental deficits which prevent him from functioning normally and which are complicated by severe substance abuse and dependence. These conditions, which were operative at the time of his offenses, triggered a dissociative state. They rendered his confession unreliable and undermined his capacity to assist in his defense. Moreover, it is my opinion that Mr. Jones' significant mental dysfunctions have existed throughout his life. In my professional opinion, his actions at the time of his offenses were significantly influenced by these impairments, and it is nearly certain that Mr. Jones was in an dissociative or altered state of consciousness during which he lacked the ability to understand the real nature and consequences of his actions. During the offenses his actions were unconsidered and impulsive.
He was unable to conform his conduct to the requirements of the law. [The conclusion reviews again in some detail the developmental insults and extreme physical and sexual torture to which Mr. Jones was subjected as described by his brothers and the impact of these insults on his psychological development. The neurological and neuropsychological evidence is reviewed and the implications reiterated. The effect of PTSD and dissociation is reviewed as well as the family history and evidence of affective disorder in this defendant and its implications. The convergence of the examiners’ findings with other data and evaluators are discussed. The divergent findings of the examining psychiatrist at the time of trial are reviewed in some detail and the paucity of historical, neurological, psychological and neuropsychological data and testing information made available to him is used to explain and excuse his inaccurate conclusions. Also reviewed was a transcript of the prisoner’s interrogation and subsequent confession and the presence of evidence of his disorders was pointed out in these transcripts. The conclusion then continues as follows.]

Impairments in his concentration, memory, insight, judgment, and thought processes interfered with his ability to aid and assist counsel in his defense. Mr. Jones would have difficulty factually and rationally understanding courtroom discussions. His attentional and memory impairments render him unable to remember a witness’s testimony for even a brief period, much less hours or days, unable to compare one witness’s testimony to his unreliable recollection of another’s, and unable to remember what he believed previously when a particular promise or question was presented to him. Additionally, because of his repressed memories, Mr. Jones could not cooperate meaningfully in any competent evaluation of his mental and neurological status. He was unable to provide a complete history of neurological insults to the brain, including instances of anoxia, brain trauma, and exposure to toxins. Additionally, he was unable to provide information regarding mitigation evidence and was unable to inform counsel that they conducted an insufficient investigation because he had no memory of the torture he suffered as a child. Given Mr. Jones’ deficits, it is unreasonable to assume that he could rationally aid and assist counsel and understand the proceedings against him.

The standards of evaluation in capital cases require that a reliable examination of the defendant include a complete psychosocial history of the client, directed mental health interviews of family members, procurement of all relevant historical records, a thorough physical and neurological evaluation, personal interview of the patient, and psychiatric and neuropsychological evaluation preferably with appropriate screening laboratory testing including EEG with naso-pharyngeal leads to assess frontal and temporal lobe impairments and appropriate radiological studies such as MRI and CT scans. Apparently these standards, accepted in the psychiatric community, were not met at the time of Mr. Jones’ trial. The appropriate evaluations conducted since his trial have found significant pathology relevant to his case. Laboratory testing and radiological studies would likely also indicate organic brain damage. A reliable expert opinion concerning a defendant’s capacity to form the requisite mental state for first degree murder must be based, at a minimum, on both the personal examination of the patient, a thorough review of the patient’s social and medical history, and appropriate diagnostic testing. Dr. ______ was not provided with Mr. Jones’ complete sociomedical history. Thus, he was unaware of the presence and devastating impact of child abuse survived by Mr. Jones and the physical
trauma to Mr. Jones' brain including multiple head injuries, periods of anoxia, and exposure to toxins, including in utero exposure. The opinions to which Dr. _______ testified were therefore incomplete, inaccurate and unreliable because they were based on medically inaccurate information. Dr. _______’s conclusion that Mr. Jones suffered from antisocial personality disorder was false and misleading. His diagnosis did not take into account Mr. Jones' severe brain damage, neurological deficits, and psychiatric disorder and missed the most obvious diagnoses, those of post-traumatic stress disorder and of organic brain damage.

I understand that the sentencer was required to consider as factors in mitigation of penalty evidence that the offense was committed while the defendant was under the influence of mental and emotional disturbance, that the defendant's capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of law was impaired as a result of mental disease or defect, or the effects of intoxication and any sympathetic or other aspect of Mr. Jones' character or record including any developmental, mental, psychiatric, or neurologic disability that affected Mr. Jones, whether or not it was a causal factor in the commission of the crime. Had I been asked to consider Mr. Jones' mental condition with reference to the sentencing factors above, I would have been prepared to testify at trial proceedings to the existence of each of these factors, which, in my opinion resulted from the torture and abuse he suffered, a possible genetic predisposition to mental illness, and other developmental and neurological factors beyond his control.

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

Executed this ___ day of December, 199__.

David Vernon Foster, M.D.

The authors believe that the mental health evaluator has the responsibility to inform counsel that these steps must be followed in order to offer a valid and reliable opinion. By conducting an exhaustive evaluation with multiple sources of information, convergent or divergent data is generated, thus dramatically increasing the odds of diagnostic precision and thus assisting the trier of fact in sentencing decisions. It is our contention that, although these steps may be costly, it is more cost effective and better serves the cause of justice, to do them up front rather than to make them part of a more costly and time consuming appeals process. Federal courts have ruled that offenders must be afforded access to competent mental health assistance and have ordered local jurisdictions to pay funds for investigating and developing multigenerational family histories, diagnostic testing, and multidisciplinary mental health assessment.
REFERENCES

1. Furman v. Georgia, 408 U.S. 238 (1972)

ABOUT THE AUTHORS

Douglas S. Liebert, Ph.D. is a clinical and forensic psychologist and the clinical director of the Family Therapy Institute of Sacramento, Inc. He has extensive experience assessing and treating survivors of trauma, and has consulted on a variety of issues in a number of capital cases. David V. Foster, M.D. is in private practice in Auburn, California, specializing in neuropsychiatry and the assessment and treatment of trauma survivors. He has been a consultant in numerous capital cases and applied the principles discussed in this article in evaluating fourteen death row inmates.