

Commentary: *Atkins* and Clinical Practice

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The American Academy of Psychiatry and the Law's Committee on the Developmentally Disabled, founded in 1990, has continually grappled with the inequities faced by persons with mental retardation within the criminal justice system. Not the least of our concerns has been capital sentencing and execution of disabled defendants. Indeed, the Committee cut its teeth on the 1989 Supreme Court decision *Penry v. Lynaugh*.¹ In that case, Justice O'Connor acknowledged the issue but demurred on the question of a constitutional ban on executing citizens with mental retardation, citing lack of consensus.

Since *Penry*, there has been a massive outpouring of interest, from within state legislatures and from advocacy and human rights groups, about a constitutional ban.² With many legislative efforts to deal with the issue, some states—though still fewer than half—have banned the execution of retarded citizens. Now, with the Supreme Court's decision in *Atkins v. Virginia*,³ the American Psychiatric Association's (APA) Council on Psychiatry and Law has taken an affirmative step by promulgating its Resource Document prepared by Professor Richard Bonnie.⁴ The Resource Document indicates that legislators will need guidance from psychiatrists and other mental health professionals in drafting post-*Atkins* statutes. We heartily agree.

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MR: What Is It? Who Has It?

Professor Bonnie has observed that the *Atkins* opinion looks at mental retardation as a clinical entity—not as a legal construct, such as competence or responsibility. Thus, whereas there are many legal and procedural issues to be ironed out by state legislatures, the clinical battleground will center on what constitutes mental retardation and who is mentally retarded. Clearly, expert testimony will be needed in individual cases.

The definition of mental retardation, unlike the differential diagnosis of its causes, is not etiologically based. Szymanski and Wilska⁵ point out that:

...[m]ental retardation is not a single, specific disorder. The term refers to...the level of a person's functioning in defined domains. It does not have a single cause, mechanism, course, or prognosis. [Affected] persons...do not constitute a homogeneous group but represent a wide spectrum of abilities, clinical presentations, and behavioral patterns [Ref. 5, p 687].

Because of its heterogeneity, clinicians skilled in assessment of this population must be utilized. Moreover, because the evaluatees may be residing in correctional rather than community settings, assessment techniques and emerging tools must be tailored.

MR and Criminal Justice: A Vertical Approach

The constitutional ban on execution of defendants with mental retardation is one of several intertwined clinical issues. The message of *Atkins* is for states to devise procedures for identifying the target population. This should be done at all levels of criminal justice. Mental retardation among criminal defendants ideally should not be an issue relegated to post-conviction relief for death row inmates, or something to be "discovered" at the time of a murder trial. By convention, an IQ score of 70 or less falls two stan-

dard deviations below the mean (100). Yet, such individuals are overrepresented in jails and prisons. As Ellis and Luckasson⁶ have pointed out, individuals with mental retardation are less likely than the average person to assert rights, to have access to quality counsel, and to protect themselves in a criminal trial. They are more likely to accept blame for things they did not do, to go along with police investigations, and to acquiesce in their punishment.

In our view, one of the most important functions of *Atkins* is to remind clinicians and attorneys to be alert to the presence of mental disability—from the time the individual is arrested until postconviction relief. While we acknowledge that citizens with mental retardation can be competent and can be criminally responsible, we endorse identification of the disability early in the criminal justice process. Whereas the Resource Document is an aid to capital sentencing, more preemptive efforts will take the death penalty off the table without the drama of the penalty phase trial. Professor Bonnie notes that states must now consider when the determination of mental retardation should be made—prior to, versus at the time of, a sentencing hearing. It is certain, however, that the question of mental retardation will not be relegated to simple mitigation, as it was after *Penry*. Therefore, we support states' efforts to identify developmentally disabled death row inmates, whose sentences may be commuted.

Numbers Game

The Resource Document underscores the essential elements of the diagnosis of mental retardation, using DSM-IV and the criteria set forth by the American Association on Mental Retardation (AAMR). In coming to an understanding of *Atkins*, the Resource Document notes that the key question is whether the individual has mental retardation—not whether the intellectual deficit reduces criminal responsibility. The latter “diminished-capacity” approach would not be included in the determination of who could be executed. Rather, the Resource Document suggests, courts are to use a categorical or diagnostic approach, thus making clinical assessment paramount.

The definition of mental retardation must include onset before age 18, significantly subaverage intellect, and significant limitations in adaptive functioning. Operationally, subaverage intellect falls two standard deviations below the mean of a validated

test instrument. This captures about 2.3 percent of the population. By convention, using for example the Wechsler Adult Intelligence Scale-III (WAIS-III), the two-standard-deviation score would be a full-scale IQ of 70. Given the standard error of mean (SEM), a full-scale IQ (FSIQ) of 70 would be expressed as a range of about 65 to 75 at a 95 percent confidence level (two SEMs). The Resource Document is careful not to get caught up in a numbers game, by rejecting a cutoff score—for example, an IQ of 70 or below. This permits play in the range of acceptable scores and does not limit the diagnostic testing to a particular test normed for an average of 100. The DSM-IV definition permits a score of approximately 70. The APA Council on Psychiatry and Law wisely opted for Professor Bonnie's recommendation that diagnostic considerations not cleave too closely to a magic number.

IQ Tests: Gold Standard or Moving Target?

Questions about psychometric assessment of intelligence have come to the fore. Prominent among these is the “Flynn effect.”⁷ Flynn has found that the national IQ score goes up about three points a decade on the same test instrument. In theory, a person with an IQ of 100 in 1932 would retest (on the same test version) at about 118 in 1990. IQ test instruments must be periodically renormed. A test version that is outdated could lead to an inflated score—with potentially lethal results!

Flynn Effect Tested

In a recent study, Kanaya and colleagues⁸ actually measured the Flynn effect among children with borderline intellectual functioning or mild mental retardation. Using the outdated Revised Wechsler Intelligence Scale for Children (WISC-R) and the current WISC-III, they compared net change among children retested with the same or different instruments. They found a decrease in measured IQ of about five points in those borderline children tested first with WISC-R and retested with WISC-III, and six points among those with mild mental retardation. The authors underscored the broad significance of this finding, listing consequences in educational, financial, legal, and military domains. They note that Atkins himself was assessed on the current WAIS-III during the year it was introduced: he scored a 59. Had he been tested on the nearly obsolete WAIS-R a year

earlier, one can speculate that he would have scored closer to 70, heightening controversy about his diagnosis.

Practical Considerations

We are concerned about how the assessments will be carried out. For example, is historical documentation of IQ adequate, or must the individual test currently at approximately 70? If the testing must be fresh, then we must be sure that the scoring has not crept upward during the current version of the instrument. Psychologists must review the basis for testing among defendants with IQs in the borderline range to see if the scores were obtained close to the end of the test's norming cycle.⁸ Conversely, if the original testing was done at the beginning of the norming cycle, might the prosecution demand retesting, which presumably would yield a higher score?⁸ If the defense has the burden of proof of current mental retardation and fresh testing is conducted, will the prosecution have the option to retest? In that event, there may be a "practice effect," with a potential inflation of scores. Can the prosecution preemptively do the testing? If so, what sort of "rebuttal" testing would be appropriate and reliable if the initial scores seem inflated? Perhaps the court could appoint a neutral expert to perform the testing. In that case, would a score unfavorable to the defendant be appealable, and what procedures would be followed? These are some of the questions that will define the battleground in ongoing and future cases and to which forensic professionals should be alerted.

Adaptive Deficits: Community Versus Death Row

Whereas forensic psychologists have experience in assessing intelligence, school psychologists are usually the ones assessing adaptive behavior. This raises the question of who is best qualified to assess adaptive behavior in adults and among prisoners. Depending on a given state's procedures, the determination of mental retardation could take place anywhere within the criminal proceedings. In addition, as we are already seeing, there is a need to raise the question of mental retardation among death row inmates whose deficits may have been overlooked for years. School psychologists are rarely called on to assess individuals older than 22 years. Perhaps the ideal professional to assess adaptive behavior would be someone already working with adults with mental retardation. Expan-

sion of the pool of qualified professionals has been advocated for some time by Petrella⁹ and others.

For reasons of scientific reliability or general acceptance (*Daubert*¹⁰ and *Frye*¹¹ tests, respectively), expert witnesses must supply acceptable tests of adaptive behavior. For criminal defendants incarcerated at length in highly structured environments, standard test instruments may not capture adaptive deficits. Whereas the diagnosis of mental retardation relies on, for example, clinical evidence of deficits in instrumental tasks of daily living, it may not be possible to get a contemporaneous reading of intrinsically community-based skills from a prison setting. Sometimes the "invisible supports" of the prison environment artificially inflate apparent adaptation. Research is needed to develop a penologically normed assessment tool for adaptive functioning of inmates. In the meantime, as the Resource Document suggests, forensic professionals should become familiar with the parameters of adaptive behavior outlined in the AAMR Manual.¹²

Psychiatry's Role

The AAMR has emphasized that mental retardation is neither a medical nor a mental disorder. Rather, it is a functional state, present since childhood, with limitations in intelligence and adaptive skills. Yet, there are as many as 250 medical causes of mental retardation—for example, genetic, toxic, metabolic, neurodegenerative, congenital and traumatic.¹³ Even so, given readily available technology, a minority of persons with mental retardation have a discernible cause—Down syndrome, fragile-X syndrome, or fetal alcohol syndrome among others. (This number may soon be as high as 60%, according to Dr. Ludwik Szymanski,¹⁴ as higher resolution brain assessments are used.) This number is likely to increase, as we understand genomics, neural morphogenesis, and microenvironmental events in the developing brain.¹⁵

Comorbidity

Whatever the cause, persons with mental retardation are susceptible to various Axis-I psychiatric conditions, with an estimated prevalence range of 40 to 70 percent.¹³ Thus, for clinicians, teachers, and caregivers, there is often inherent ambiguity in the clinical presentation. This is of practical significance when we seek historical evidence of mental retardation for forensic ends. Records may show that, due to

overt behavioral problems (conduct disorder or oppositional-defiant disorder, for example), the child with mental retardation had been the subject of turf wars between mental health and developmental disability providers. Child Study Team reports often list specific learning disabilities without a specified diagnosis of mental retardation.

Multidisciplinary Approach

While IQ numbers may speak for themselves, forensic professionals may have to read between the lines of school records to extract the needed diagnosis. Forensic psychiatrists have the potential to be valuable in this effort, where there is residual ambiguity about whether the defendant's condition is best explained by an Axis I condition, by mental retardation, or by a complex interaction. The diagnostic expertise of forensic psychiatrists enables us to articulate how mental illness does not erase the more static deficits of mental retardation. Judges and juries need education about the enduring nature of the condition.

With respect to Axis III conditions producing mental retardation, there may be forensic roles for other medical professionals. These would include neurology, pediatrics, genetics, and others. When medical causes of the condition are known, expert testimony should be adduced to educate the court. This renders the diagnosis more three-dimensional, perhaps reducing reliance on the numbers. In this journal, Beck¹⁶ described the case of Mr. B., whose deficits were multiply determined—fetal alcohol effect, gross abuse, social chaos, and substance abuse. He emphasized the importance of the forensic psychiatrist in explaining the multiple causes of psychopathology throughout the developmental period. This model is applicable in post-*Atkins* analyses.

Credentials

When medical causes are not identified, physicians can aid in the explanation of adaptive deficits. The Resource Document makes it clear that establishing an IQ and assessing adaptive deficits should be done by persons “qualified by training and experience” to make the diagnosis of mental retardation. While psychiatrists frequently rely on test results to make the diagnosis, very few are skilled in the administration of standard test instruments. Given the importance of accurate, reliable, and scientifically supportable testing in the capital-sentencing arena, we

suggest that training programs consider broadening trainees' knowledge base in psychometrics, so that there will be smoother coordination between psychiatric and psychological testimony.

Explaining the Big Picture

It is unlikely that forensic psychiatrists will perform the testing of record in capital cases. However, there will be a significant role for psychiatrists. For example, we can provide testimony on components of cognition and personality that are not easily captured by quantitative analysis—social intelligence, suggestibility, acquiescence, moral development, and vulnerability to social pressure. The history of an individual with mental retardation is replete with episodes of adversity and adaptation. The psychiatric expert witness can assist the trier-of-fact in understanding, for example, how such an individual was or was not able to cope with social and developmental roadblocks. Ironically, the prosecution will cite how, with assistance, the defendant learned to adapt in various domains, arguing that the adaptive-functioning criterion was not met. Accordingly, expert witnesses should be fully familiar with evolving standards in assessment and quantification of adaptation. When necessary, courts also will need experts familiar with immigrant populations and subcultural issues that affect testing.

The Road Ahead

The American public has become aware over time that capital punishment cannot be indiscriminately administered and that retribution is not the only dynamic in play. This concept echoes throughout the jurisprudence of criminal responsibility over hundreds of years.³ No state condones execution of incompetent or insane persons. The Constitution, while prohibiting punishments that are cruel and unusual, continues to require interpretation in regard to specified populations. In 1986 the Supreme Court at last tackled the question of executing a person who was too mentally ill to understand the punishment and its purpose.¹⁷ In *Ford v. Wainwright*, we have a constitutional bar to executing a person who has become “insane” in prison—that is, one who is presently incompetent. Justice Marshall, delivering the majority opinion, noted that execution of insane persons has neither retributive nor deterrence value, and “simply offends humanity.”

There is no valid penological purpose in executing persons with mental retardation. This argument, among others, was used by *amici curiae* in *Penry* and in *Atkins* as well. Under *Ford* there is the possibility that competence for execution can be restored, as occurred in the case of Charles Singleton, who was executed in Arkansas in January 2004.¹⁸ There is the presumption in *Atkins* that a person with mental retardation has a condition that cannot be reversed. That is, once the condition is judged to be present, the death penalty is permanently off the table. Just as states are required to have constitutionally sound procedures for determining execution competency under *Ford*, they must now devise procedures for determining a diagnosis of mental retardation. The Resource Document's section on assessment is a comprehensive and flexible outline for the types of information that can be used in post-*Atkins* determinations.

To avoid complication of an already difficult matter, the APA Council only alluded to extending statutory language to include persons with pervasive developmental disorders, for example, autism. As the Resource Document notes, severe developmental disorders often include mental retardation, implying that such persons would not tend to be prosecuted. We look forward to this elaboration by the Council and by state legislatures and to a significant role for child psychiatrists in elucidating the connections between this group of Axis I disorders and the condition of mental retardation.

We envision an enduring role for scientific knowledge in the determination of mental retardation for legal purposes, with forensic psychiatry and psychology figuring prominently. As forensic professionals concerned about the mentally disabled within the criminal justice system, we gratefully acknowledge the APA Council's work and Professor Bonnie's guidance. Our role is to operationalize the principles within the Resource Document. The *Atkins* decision

is less a roadmap than an imperative to marshal multidisciplinary knowledge, thus providing a shield for an already vulnerable population.

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