

Commentary: Atkins on a Diet—a Fit but Lean Guide for Policy-Makers

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It comes as no surprise that the resource document Professor Richard Bonnie has crafted for the APA Council on Psychiatry and Law¹ to aid in the implementation of *Atkins v. Virginia*² is clearly written and to the point. What was not expected, however, is the document's significantly limited scope. Because the document is intended as a resource for mental health professionals who may be consulted in the development of legislation and policy, its avoidance of such extraneous (and controversial) issues as the rationale for the Court's decision in *Atkins* may be understandable. But its brevity and narrow focus may short-change policy-makers in states receptive to a broader reading of the decision.

The Supreme Court ruled in *Atkins* that individuals with mental retardation must be spared the death penalty—that execution of such individuals constitutes “cruel and unusual punishment” because no one so diagnosed acts “with the level of moral culpability that characterizes the most serious adult criminal conduct.” The Court declared that “[i]f the culpability of the average murderer is insufficient to justify the most extreme sanction available to the state, the lesser culpability of the mentally retarded offender surely does not merit that form of retribution” (Ref. 2).

The Court has never offered such a characterization of offenders with other mental disabilities, though some (notably traumatic brain injury) cause deficits closely resembling those of mental retardation. It might be premature to suggest that *Atkins*

signals a willingness among the Justices to consider a broader range of disabilities as incompatible with the death penalty, but certainly legislatures responding to *Atkins* are free to consider the significance of these disabilities when rethinking their capital sentencing laws. (Although states may not deny protections guaranteed by the Constitution, nothing prevents them from extending additional protections not so guaranteed.) That the APA Council on Psychiatry and Law makes no mention of this possibility is curious.

The Council's narrow response to the decision in *Atkins* may reflect a judgment that, by avoiding questions not squarely addressed by the Court, its recommendations will find broader acceptance among policy-makers across the country. But the Council may be missing a golden opportunity to show these officials the way to a fairer and clinically more meaningful response to the concerns underlying *Atkins*.

The Council expressly excludes from *Atkins*' protections individuals with brain injuries suffered after the age of 18, reasoning that the “Court's decision to bar death sentences for persons with mental retardation is grounded in presumed deficits in moral reasoning arising from disordered development” (Ref. 1, p 306). This position may be unduly restrictive, however, as it fails to take account of the Court's other rationales for its decision: (1) that “diminished ability to understand and process information, to learn from experience, to engage in logical reasoning, or to control impulses. . .also make it less likely that [people with mental retardation] can process the information of the possibility of execution as a penalty and, as a result, control their conduct based upon that information”; (2) that exempting people with this level of disability will not “lessen the deterrent effect of the death penalty with respect to offenders

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who are not mentally retarded;” and (3) that “the risk ‘that the death penalty will be imposed despite factors which may call for a less severe penalty’ . . . is enhanced not only by the possibility of false confessions, but also by the lesser ability of mentally retarded defendants to make a persuasive showing of mitigation in the face of prosecutorial evidence of one or more aggravating factors” (Ref. 2). These considerations apply with equal force to individuals with serious mental disabilities other than mental retardation, and legislatures responsible for implementing *Atkins* should be so advised, even if the Court’s limited holding in *Atkins* may permit them to ignore the advice.

It is encouraging that the Council recognizes “pervasive developmental disorders” as being within *Atkins*’ purview. But by hesitating to propose language addressing these disorders (because doing so “at this time would unnecessarily complicate legislative efforts to respond to the *Atkins* decision in an expeditious manner”), the Council fails to strike while the iron is hot. Legislatures are motivated to respond to *Atkins* now; whether they will consider calls for clarifying legislation in future years, without further Court mandate, is doubtful.

In most other respects, the Council’s guidance in this document is sound. Its offering of alternative definitions of mental retardation, based on those appearing in the DSM and the Manual of the American Association for Mental Retardation (AAMR), is sensible, if not bold. And its rejection of IQ cutoff scores to define “significant limitations in intellectual functioning” reflects important professional concerns. The Council cites the variation in scoring norms and the imprecision of IQ scores, but perhaps the greatest concern for practitioners is the ethical dilemma cutoff scores present for those facing capital defendants in the borderline range. To require an expert to report a score of 71 when 70 represents the line between life and death, tests the limits of ethical practice.

The Council’s standards for assessment are brief but touch on the major considerations for mental health professionals who would serve as experts. As guidance for policy-makers, however, they might have been more comprehensive. Certainly, as the document makes clear, secondary source information is crucial in the assessment of mental retardation—particularly in a forensic context—and evaluators must take care to review records and interview

third parties. But these secondary sources can be difficult for mental health professionals to access, particularly if they are covered by the Health Insurance Portability and Accountability Act (HIPAA). Accordingly, the Council’s recommendations might have gone farther, calling, for example, for laws requiring courts to order the release of pertinent records and directing the attorneys to obtain copies for the evaluators’ use.

Who may qualify as an expert in a capital case is a matter of profound importance. The Supreme Court, recognizing that “the penalty of death is qualitatively different” from other criminal sanctions,³ consistently has demanded an enhanced concern for reliability in such cases. Thus, it is not surprising that the Council would require *Atkins* experts to have specialized training and experience in the diagnosis of mental retardation and in the use of intelligence tests and other pertinent measures.

What is surprising, however, is that the Council would accept as experts mental health professionals having no specialized training or experience in forensic assessment. The Council’s suggestion that, to be qualified, such professionals need simply consult with colleagues “with such experience” may fall short of the mark, at least where the professional is one appointed as the expert for the defendant. It may be understandable that the Council would want to avoid excluding the testimony of generalists offered as experts by the parties in a case, but to deny the defendant—who, if indigent, must rely on the expert the court assigns—the services of a forensic specialist seems short sighted. The American Bar Association’s Criminal Justice Mental Health Standards (Standard 7-3.10)⁴ provide that:

[N]o professional should be appointed by the court to evaluate a person’s mental condition unless the court determines that the professional’s qualifications include . . . sufficient forensic knowledge, gained through specialized training or an acceptable substitute therefor, necessary for understanding the relevant legal matter(s) and for satisfying the specific purpose(s) for which the evaluation is being ordered.

It is true that, unlike so many other psycholegal questions mental health professionals may be asked to address in a criminal case (e.g., competence to stand trial, criminal responsibility), whether an individual has mental retardation is one most generalists may feel they can handle. But criminal defendants present special challenges. Particularly in a capital case, and certainly where a positive diagnosis may

have such great outcome significance, the potential for malingering is high, and the demands on the expert's objectivity are extreme. Forensic evaluators are equipped to face these challenges; generalists may not be.

In many cases in which mental retardation is diagnosed, moreover, courtroom testimony is required. The skills necessary to communicate one's findings effectively in court and to withstand the rigors of cross-examination demand an expert with specialized training and experience. To expect a generalist, consulting with a specialist, to offer the requisite level of service may be naïve.

Despite its shortcomings, the APA resource document is a useful guide for mental health professionals wishing to contribute to the legislative implementa-

tion of *Atkins v. Virginia*. Indeed, its simplicity may be its greatest virtue, as it steers clear of the ambiguities and controversies that so often derail legislative efforts. In states ready to address the broader implications of *Atkins*, however, the guidance this document provides may be incomplete. In these states, mental health professionals and policy-makers must be prepared to look elsewhere for help.

References

1. Bonnie RJ: The American Psychiatric Association's Resource Document on Mental Retardation and Capital Sentencing: Implementing *Atkins v. Virginia*. *J Am Acad Psychiatry Law* 32:304-8, 2004
2. *Atkins v. Virginia*, 536 U.S. 304 (2002)
3. *Woodson v. North Carolina*, 428 U.S. 280, 305 (1976)
4. *Criminal Justice Mental Health Standards*, § 7-3.10. Chicago, IL: American Bar Association, 1984