The American Psychiatric Association's Resource Document on Mental Retardation and Capital Sentencing: Implementing *Atkins v. Virginia*

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State legislatures need guidance in implementing the United States Supreme Court's decision in *Atkins v. Virginia* barring execution of mentally retarded offenders. In this Resource Document, the American Psychiatric Association's Council on Psychiatry and Law, the component charged with developing policies and positions relating to forensic psychiatry, recommends statutory language addressing the definition of mental retardation, procedures relating to its assessment, and qualifications of testifying experts.

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In its recent decision in *Atkins v. Virginia*,[1] the United States Supreme Court ruled that the Eighth Amendment's prohibition against "cruel and unusual punishments" bars execution of mentally retarded offenders. At the time of the *Atkins* decision, 18 states and the federal government had already adopted laws categorically excluding defendants with mental retardation from the class of offenders convicted of capital crimes who can be sentenced to death. Several additional states, including Virginia, have adopted such statutes in the wake of the Supreme Court's decision. However, these statutes vary widely, and the Court's opinion in *Atkins* gave the states little guidance about how to implement the ruling or about the features of the existing statutes that are either constitutionally required or constitutionally permissible. Legislatures in the 38 states that enforce the death penalty are now reviewing their capital sentencing statutes in light of *Atkins* and other recent Supreme Court rulings pertaining to capital sentencing procedures.[2]

One of the striking aspects of the *Atkins* decision is that the constitutional prohibition appears to be framed in the language of a clinical diagnosis—"mental retardation"—and not in terms of a traditional legal concept, such as competence or responsibility. For this reason, state legislators can be expected to seek the guidance of psychiatrists and other mental health professionals in the drafting of post-*Atkins* statutes. This Resource Document is being published to assist members of the district branches of the American Psychiatric Association (APA) and other professional groups as they respond to legislative efforts to implement the *Atkins* decision in a way that is grounded in scientific knowledge and clinical experience and is consistent with the Supreme Court's ruling.

Many of the issues that must be resolved in drafting a post-*Atkins* statute are purely legal in nature and do not require or imply a need for psychiatric expertise. The two main legal questions are: who should bear the burden of persuasion on the matter of men-

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tal retardation, and should an initial determination of mental retardation be made in a pretrial hearing by the judge before the capital sentencing proceeding. Alternative approaches to these questions are reflected in the statutes of Virginia[3] and New York.[4] Ellis[5] provides a full review of these procedural issues.

This document addresses three topics of particular concern to psychiatrists and other mental health professionals:

1. the definition of mental retardation and whether *Atkins* bars death sentences in a broader category of cases;

2. procedures to be followed by professionals who are charged with assessing whether capital defendants have mental retardation;

3. qualifications of experts selected to conduct these evaluations and to offer expert opinion on the pertinent issues.

Definition

Several problems must be resolved in defining mental retardation, and state statutes reflect some variation on them:

1. The first question is whether mental retardation in this context should be defined in terms of a clinical diagnosis or in terms of diminished capacity to engage in mental tasks thought to be especially relevant to the assessment of criminal responsibility. Almost every state statute takes the diagnostic approach rather than the diminished-capacity approach, and the Council believes that a diminished-capacity approach is inconsistent with the Supreme Court's reasoning in *Atkins*. The Court's opinion repeatedly describes its holding as banning execution of "mentally retarded offenders," and the excluded category is defined diagnostically (not in terms of diminished capacity) in 17 of the 18 state statutes (as well as the federal statute) to which the Court refers in concluding that a national consensus has emerged against execution of the mentally retarded. In a particularly pertinent passage, Justice Stevens noted that "[t]o the extent that there is serious disagreement about the execution of mentally retarded offenders, it is in determining which offenders are in fact retarded" (Ref. 1, p 317), not whether defendants who are really retarded should be executed. In short, if a state were to define the excluded category in a way that allowed a person with an undisputed diagnosis of mental retardation to be sentenced to death and executed, the Eighth Amendment would forbid the execution, and the statute would be unconstitutional as applied to that case.

2. Assuming that a diagnostic approach is taken, there are two main sources of definitional guidance: the manual of the American Association of Mental Retardation (AAMR) and the APA's Diagnostic and Statistical Manual. Although these two manuals use somewhat different language, they are conceptually equivalent. Each defines mental retardation as causing significant limitations in intellectual functioning and in adaptive behavior and as having developmental onset before the age of 18 years.

- In DSM-IV, mental retardation is defined as a disorder, with an onset before 18 years, characterized by "significantly subaverage intellectual functioning" and "concurrent deficits or impairments in present adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety" (Ref. 6, p 39).
- In the 2002 AAMR Manual, mental retardation is defined as a disability originating before age 18, "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills" (Ref. 7, p 13).

The AAMR Manual was revised in 2002 and provides the more recent of the two definitions. A state statute would be on safe ground in using either of these definitions or in intermingling the two. The Council has proposed alternatives, using the operative language of each of these two definitions in this Resource Document.

3. A key difficulty in legislative drafting has been whether "significant limitation in intellectual functioning" should be defined in terms of performance on so-called "IQ" tests and, if so, whether the definition should include specific reference to a cutoff score, as some state laws do. In the Council's view, incorporation of a specific cutoff score is inappropriate, not only because different tests have different scoring norms, but also because designating a specific score ignores the standard error of measurement and attributes greater precision to these measures than

they can support. The Council has defined a "significant limitation in intellectual functioning" as performance at least two standard deviations below the mean on an approved test rather than as a specific cutoff score.

The DSM-IV diagnostic criteria define significantly subaverage intellectual functioning as "an IQ of *approximately* 70 or below on an individually administered IQ test" (Ref. 6, p 46; emphasis added). The accompanying text makes it clear that the score of 70 is meant to be an approximation of a score two standard deviations below the mean, taking into account the standard error measurement, for the particular instrument being used.

4. The greatest challenge is to define a "significant limitation in adaptive behavior" because the DSM-IV and AAMR definitions use different language to operationalize the concept of adaptive functioning in terms of specific adaptive tasks. Because the concept is still being elaborated by experts in the field, standardized instruments are in a continuing process of development. It should be noted that the AAMR definition reflects the most recent scientific understanding of the concept of adaptive behavior. Under this conceptualization, explained in the AAMR Manual, the various skill areas mentioned in the previous AAMR definition and in the DSM-IV definition exemplify three basic domains of adaptive functioning (conceptual, social, and practical). The manual includes tables that sort various skills into these three domains and explains how currently available instruments operationalize and measure adaptive behavior.

5. Following the diagnostic approach endorsed in *Atkins*, the Council includes developmental origin in the definition (thereby excluding conditions involving deficits in intellectual and adaptive functioning acquired due to trauma or disease after age 18) on the basis that the Supreme Court's decision to bar death sentences for persons with mental retardation is grounded in presumed deficits in moral reasoning arising from disordered development. None of the statutes on which the Supreme Court relied in *Atkins* includes conditions acquired during adulthood, and such cases do not often arise. For anyone concerned that requiring developmental onset could lead to unfair treatment of defendants with adult-onset intellectual and adaptive deficits, it must be remembered that an individualized determination of diminished capacity at the time of the offense is still required in cases in which persons with subaverage intellectual functioning have not been categorically excluded under *Atkins*.

The *Atkins* rationale also extends, in the Council's view, to some conditions in the category of "pervasive developmental disorders," especially autism. Ideally, an exclusionary provision should include these disorders, and eventually the Council will attempt to develop appropriate statutory language. However, because these disorders are usually accompanied by mental retardation, none of the exclusionary statutes covers them, and no prosecutions appear to have been brought in such cases, the Council concluded that proposing additional language at this time would unnecessarily complicate legislative efforts to respond to the *Atkins* decision in an expeditious manner.

Statutory language for the two alternative definitions follows.

The AAMR Definition

Mental retardation is a disability originating before the age of 18 and characterized concurrently by (1) significant limitations in intellectual functioning and (2) significant limitations in adaptive behavior, as expressed in conceptual, social, and practical adaptive skills. "Significant limitations in intellectual functioning" means performance that is at least two standard deviations below the mean, considering the standard error of measurement for the specific instruments used, as well as their strengths and limitations in the context of the particular assessment.

The DSM Definition

Mental retardation is a disorder, with onset before 18 years, characterized by significantly subaverage intellectual functioning and concurrent deficits or impairments in present adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. "Significantly subaverage intellectual functioning" means performance that is at least two standard deviations below the mean, considering the standard error of measurement for the specific instruments used, as well as their strengths and limitations in the context of the particular assessment.

Obviously it is possible to combine language from the two definitions. In Virginia, for example, legislators sympathetic to prosecutorial or defense perspec-

tives tended to draw on the language in each definition that seemed more congenial to their point of view. In the end, the Virginia statute adopted the AAMR definition with the sole exception of using the DSM-IV language "significantly subaverage" intellectual functioning rather than "significant limitation in" such functioning, as used in the AAMR (see Ref. 3).

Assessment

In light of the heightened "need for reliability" in capital sentencing,[8] it is particularly important to promote the highest quality of assessment and to minimize unnecessary variation from accepted professional standards. The diagnosis of mental retardation lends itself to greater specification of practice standards than other forensic assessments, and the Council has embraced the approach taken in the Virginia statute. Specifically, state laws should:

- require use of at least one standardized test for measuring intellectual functioning, administered in conformance with accepted professional practice by a person skilled in the administration, scoring, and interpretation of such tests;
- encourage use of at least one standardized measure of adaptive behavior while recognizing the ultimate need for clinical judgment;
- require efforts to obtain pertinent written records and to conduct interviews with people who have interacted with the defendant; and
- permit, but not require, the assessment of mental retardation to be combined with other mental health assessments conducted in the case and provide all the procedural protection applicable to other forensic mental health assessments in capital cases.

Assessments of mental retardation under this section shall conform to the following requirements:

1. Assessment of intellectual functioning shall include administration of at least one standardized measure generally accepted by the field of mental health assessment and appropriate for administration to the particular person being assessed, taking into account cultural, linguistic, sensory, motor, behavioral, and other individual factors. Testing of intellectual functioning should be carried out in conformity with accepted professional practice by a person skilled in the administration, scoring, and interpretation of such tests, and, whenever indicated, the assessment should include information from multiple sources.

2. Assessment of adaptive behavior shall be based on multiple sources of information, including clinical interview; psychological test results; and educational, correctional, and vocational records, and shall include, whenever feasible, at least one standardized measure for assessing adaptive behavior, administered by a person skilled in the administration, scoring, and interpretation of such instruments, in accordance with methods generally accepted by the field of mental health assessment and appropriate for administration to the particular person being assessed, taking into account the environments in which the person has lived, as well as cultural, linguistic, sensory, motor, behavioral, and other individual factors. In reaching a clinical judgment regarding whether the person exhibits significant limitations in adaptive behavior, the examiner shall give performance on standardized measures whatever weight is clinically appropriate in light of the person's history and characteristics and the context of the assessment.

3. Assessment of developmental origin shall be based on multiple sources of information generally accepted in the field of mental health assessment, including, whenever available, educational, social service, medical records, prior disability assessments, parental or caregiver reports, and other collateral data, recognizing that valid clinical assessments conducted during the person's childhood may not have conformed to current practice standards.

Qualifications of Experts

The expert selected or appointed to conduct mental retardation evaluations in capital cases should be a psychiatrist or psychologist who is qualified by training and experience to make a diagnosis of mental retardation. The testing of intellectual functioning and adaptive behavior should be carried out by clinicians who have the necessary skill and experience. Finally, if the expert appointed or selected lacks training and experience in conducting forensic assessments and testifying in criminal adjudications, he or she should obtain a consultation with a psychiatrist or other qualified professional with such experience.

An expert appointed by the court to assess whether a capital defendant has mental retardation or whose opinion is admitted into evidence on this matter should be a

psychiatrist or clinical psychologist who is qualified by training and experience to make a diagnosis of mental retardation. Standardized testing required under this section and relied on by the appointed or testifying expert shall be carried out by a mental health professional skilled in the administration, scoring and interpretation of intelligence tests and measures of adaptive behavior. If the expert lacks training and experience in conducting forensic assessments and testifying in criminal adjudications, he or she should obtain a consultation with a psychiatrist or other qualified professional with such experience.

References

1. Atkins v. Virginia, 536 U.S. 304 (2002)
2. Ring v. Arizona, 536 U.S. 584 (2002)
3. Va. Code. Ann. § 19.2-264.3:1.1, 1.2 (Michie Supp. 2003)
4. N.Y. Crim. Proc. Law § 400.27 (12)-(14) (McKinney Supp. 2004)
5. Ellis JW: Mental retardation and the death penalty: a guide to state legislative issues. Ment Phys Disabil Law Rep 27:11–24, 2003
6. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (ed 4). Washington, DC: American Psychiatric Association, 1994
7. American Association on Mental Retardation: Mental Retardation (ed 10). Washington, DC: AAMR, 2002
8. Woodson v. North Carolina, 428 U.S. 280, 305 (1976)