Special Feature

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

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In *Atkins v. Virginia*,[1] the U.S. Supreme Court ruled that the Eighth Amendment's prohibition against "cruel and unusual punishments" bars the execution of offenders with mental retardation. 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 are punishable by death. Several additional states, including Virginia, adopted such laws in the wake of *Atkins*. However, these state laws vary widely. The Court in *Atkins* gave states little guidance about how to implement its ruling or what features of the existing statutes are constitutionally required or 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.

Many of the issues that need be resolved in drafting a post-*Atkins* statute are purely legal in nature and do not require or implicate psychiatric expertise. The two main legal issues are: (1) who should bear the burden of persuasion on the issue of mental retardation, and (2) whether a judge in a pretrial hearing should make an initial determination of mental retardation before the capital sentencing proceeding. Alternative approaches to these questions are reflected in the statutes of Virginia[3] and New York.[4]

James W. Ellis,[5] Regents Professor of Law at the University of New Mexico who argued for the petitioner in *Atkins*, provides a full review of these procedural issues.

I. Defining Mental Retardation

The first question is whether mental retardation in this context should be defined in terms of a clinical diagnosis or rather 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. The American Psychiatric Association (APA) Council believes that a diminished capacity approach is inconsistent with the Supreme Court's reasoning in *Atkins*.

The Court in *Atkins* repeatedly describes its holding as banning the execution of "mentally retarded offenders." Moreover, the excluded category is defined diagnostically in 17 of the 18 state statutes (as well as the federal statute), which the Court refers to in concluding that a national consensus has emerged against the execution of persons with mental retardation. 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,"[6] 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.

Assuming that a diagnostic approach is taken, there are two main sources of definitional guidance: the American Association of Mental Retardation's *Mental Retardation* (AAMR Manual) and the APA's (DSM-IV). Although these manuals use somewhat different language, they are conceptually equivalent; each requires significant limitations in intellectual functioning and in adaptive behavior, as well as developmental onset before age 18.

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."[7] In the 2002 AAMR Manual, mental retardation is defined as a disability originating before age 18, "characterized by significant limitations both on intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills."[8] The AAMR Manual was revised in 2002 and is the more recent of the two definitions.

A state statute would be on safe ground in using either of these definitions or some interweaving of the two. The Council has proposed alternative definitions, using the operative language of each of these two definitions.

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 cut-off score, as some state laws do. In the Council's view, incorporation of a specific cut-off 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.

The DSM-IV diagnostic criteria define significantly subaverage intellectual functioning as "an IQ of *approximately* 70 or below on an individually administered IQ test."[9] (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 of measurement, for the particular instrument being used.

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.

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. 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 upon which the 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, an individualized determination of diminished capacity at the time of the offense is still required for 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 (DSM-IV 299.00). 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.

In conclusion, the Council's statutory language for two alternative definitions of mental retardation is as follows:

- Based on AAMR Definition—*Mental retardation is a disability, originating before the age of 18, 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.*

- Based on DSM Definition—*Mental retardation is 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. "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 perspectives tended to draw on the language in each definition that seemed more congenial to their point of view. In the end, the Virginia statute adopts 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.[10]

II. Assessing Mental Retardation

In light of the "heightened need for reliability" in capital sentencing,[11] 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. 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 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 should provide all of the procedural protection applicable to other forensic mental health assessments in capital cases.

The Council adopts the following statutory language for

assessments—*Assessments of mental retardation 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 testing 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.

III. 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 selected or appointed 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.

The Council's statutory language for qualifications of experts is as follows:

An expert appointed by the court to assess whether a capital defendant has mental retardation, or whose opinion is admitted into evidence on this issue, 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 upon 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.

[* This Resource Document was drafted by Mr. Bonnie and was approved by the American Psychiatric Association (APA) Council on Psychiatry and Law in May 2003. This article is being published with the permission of the *Journal of the American Academy of Psychiatry and the Law*, in which it will appear in the summer of 2004. Mr. Bonnie is John S. Battle Professor of Law, Professor of Psychiatric Medicine, and Director of the Institute of Law, Psychiatry and Public Policy, University of Virginia Schools of Law and Medicine, Charlottesville VA. Address correspondence to Richard J. Bonnie, LL.B., 580 Massie Rd., Charlottesville, VA 22903. E-mail: rbonnie@virginia.edu]

NOTES

1. 536 U.S. 304 (2002), 26 *Mental & Physical Disability L. Rep.* (MPDLR) 640 (2002).
2. Ring v. Arizona, 122 S. Ct. 2428 (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. James W. Ellis, "Mental Retardation and the Death Penalty: A Guide to State Legislative Issues," 27 MPDLR 11 (2003).
6. Atkins, 536 U.S. at 317.
7. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 46 (4th ed. 1994).
8. American Association on Mental Retardation, Mental Retardation 13 (10th ed. 2002).
9. American Psychiatric Association, *supra* note 7, at 46.
10. Va. Code Ann. §19.2-264.3:1.1A. (Michie Supp. 2003).
11. Woodson v. North Carolina, 428 U.S. 280, 305 (1976).