MENTAL RETARDATION AND CRIMINAL JUSTICE:

ATKINS, THE MENTALLY RETARDED, AND PSYCHIATRIC METHODS FOR THE CRIMINAL DEFENSE ATTORNEY

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INTRODUCTION

On June 20, 2002, the United States Supreme Court held in Atkins v. Virginia that the execution of individuals with mental retardation who were found guilty of capital murder constitutes "cruel and unusual punishment," which is prohibited by the Eighth Amendment to the United States Constitution. Henceforth, in certain death penalty cases, an important adversarial struggle will center on whether the defendant is a person with mental retardation. For the defendant, this amounts to a life or death question. The Atkins Court left to the individual states the determination as to

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1 Atkins v. Virginia, 536 U.S. 304, 321 (2002). The Court stated, "Construing and applying the Eighth Amendment in the light of our 'evolving standards of decency,' we therefore conclude that such punishment is excessive and that the Constitution 'places a substantive restriction on the State's power to take the life' of a mentally retarded offender." Id. citing U.S. CONST. AMEND. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted."); Ford v. Wainwright, 477 U.S. 399, 405 (1986).
the criteria necessary to identify an offender who is mentally retarded.²

This essay will attempt to provide some guidance as to the evaluation of the mentally retarded under the Atkins holding. In Part II, this piece provides a brief overview of the Atkins decision. In Part III, some issues associated with evaluation of the mentally retarded are discussed, including particular definitions and tests that may be relevant to the criminal defense attorney in his or her efforts to define and evaluate his/her client as mentally retarded. In Part IV, we discuss some of the ramifications of the Atkins decision on the mentally ill. Finally, in Part V, the essay offers some concluding comments.

I. The Atkins Decision

Justice Stevens, in delivering the opinion of the Supreme Court, observed that a claim of excessive punishment must be judged in accordance with current standards.³ The Court then reasoned that the best representation of current standards and/or values is found in individual states’ legislation.⁴ However, in the end, the final judgment as to the acceptability of the death penalty under the Eighth Amendment lies within the purview of the Court.⁵ The

¹ Id. at 317 (“To the extent there is serious disagreement about the execution of mentally retarded offenders, it is in determining which offenders are in fact retarded... Not all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus. As was our approach in Ford v. Wainwright, with regard to insanity, ‘we leave to the State[s] the task of developing appropriate ways to enforce the constitutional restriction upon their execution of sentences.’ (quoting Ford v. Wainwright, 477 U.S. at 416-417 (alterations in original)).
² Id. at 311 (“A claim that punishment is excessive is judged not by the standards that prevailed in 1685 when Lord Jeffreys presided over the ‘Bloody Assizes’ or when the Bill of Rights was adopted, but rather by those that currently prevail.”).
³ Id. at 312 (“We have pinpointed that the ‘clearest and most reliable objective evidence of contemporary values is the legislation enacted by the country’s legislatures.’”) (quoting Penny v. Lynaugh, 492 U.S. 302, 331 (1989) [hereinafter Penny I]).
⁴ Id. at 312 (“We also acknowledged in Coker that the objective evidence, though of great importance, did not ‘wholly determine’ the controversy, ‘for the Constitution contemplates that in the end our own judgment will be brought to bear on the question of the acceptability of the death penalty under the Eighth Amendment.’”) (quoting Coker v. Georgia, 433 U.S. 584, 597 (1977)).
⁵ Justice Scalia, in his dissent, vehemently attacks this particular approach by the court and finds that “the arrogance of this assumption of power takes one’s breath away.” Id. at 348. It is Justice Scalia’s view, joined by Chief Justice Rehnquist and Justice Thomas, that “a majority of the small and unrepresentative segment of our society that sits on this Court has bestowed upon itself the power to determine the national consensus, when no national consensus exists.” Id. at 348-49.
Court then reviewed a number of state legislatures that had already rejected imposing the death penalty upon mentally retarded offenders. The Court acknowledged that mentally retarded persons who meet the law's requirements for criminal responsibility should be tried and punished when they commit crimes. The Court then afforded those offenders with mental retardation judicial recognition of their disabilities in the areas of reasoning, judgment, and impulse control. They exhibit a diminished capacity to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others. The Court acknowledged that mentally retarded offenders do not act with the level of moral culpability that characterizes the most serious adult criminal conduct.

A serious problem arises for defense counsel in the Court's judicial recognition that the mentally retarded offenders manifest both cognitive and behavioral impairments. Though the Court saved the mentally retarded from the death penalty, it may have inadvertently increased the prison sentence for crimes of less magnitude. The mentally retarded, because of the disabilities enumerated by the Court, may now be classified as more dangerous to the community than those offenders with a more normal mental capacity.

In the dissent, Justice Scalia clearly laid out the future battlefield in courtrooms across the country regarding mental retardation and the death penalty. The adversarial struggle will be in separa-

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6 Id. at 313–17.
7 Id. at 306.
8 Id.
9 Id. at 318.
10 Id. Justice Scalia points out that the severely and profoundly mentally retarded offenders, commonly known as “idiots” in English common law, were recognized as requiring special treatment, as they, like “lunatics,” suffered a “deficiency in will” rendering them unable to tell right from wrong. Id. at 340.
11 Id. at 306.
12 Penalty I, 492 U.S. at 324.
13 See id. (“Penalty’s mental retardation and history of abuse is thus a two-edged sword: it may diminish his blameworthiness for his crime even as it indicates that there is a probability that he will be dangerous in the future.”).
14 Atkins, 536 U.S. at 340 (Scalia, J., dissenting) (“The Court makes no pretense that execution of the mildly mentally retarded would have been considered ‘cruel and unusual’ in 1791. Only the severely or profoundly mentally retarded, commonly known as ‘idiots,’ enjoyed
ing offenders with mild mental retardation from those with borderline intelligence. Indeed, for those offenders whose IQ and Adaptive Behavior test scores lie within the standard error of measurement (usually three to five points on either side of the line between mild mental retardation and borderline intelligence), additional medical records, behavioral observations, and testimony of reliable witnesses may mean the difference between life and death.

II. DEFINING RETARDATION AND RELEVANT TESTING

A. Defining Mental Retardation: Problems with Age and Developmental Period

Most definitions of mental retardation are similar, though there are some subtle but important differences. The DSM-IV and the AAMR provide that the deficit in the individual's IQ and

任何特殊状态下的法律要求。他们，如疯子，遭受一种‘缺陷在意志’，使他们不可能做出正确的决定。

15 Id.
16 AM. ASS'N ON MENTAL RETARDATION, MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 51-71 (2002) [hereinafter AAMR].
   A. Significantly subaverage intellectual functioning: an IQ approximately 70 or below on an individually administered IQ test.
   B. Concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
   C. The onset is before age 18 years.
18 The AAMR is a lay organization founded in 1876 for the purpose of understanding, defining, and classifying the condition of mental retardation. "Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18."
19 Id. supra note 16, at 1. The AAMR definition of mental retardation has evolved over the years to its present wording in 2002. Forensic psychiatry and psychology experts in the evaluation of individuals who have been accused or convicted of capital murder see the AAMR definition relating to adaptive behavior as quite broad and vague, i.e., what is a significant limitation in conceptual and/or practical adaptive skills? Some predict that the 2002 AAMR definition, though worthwhile in helping individuals with mental retardation in the community, will cause great confusion in the criminal justice system. See Hearing on Texas State H.B. 614 Before the House Committee on Criminal Jurisprudence (2003) (testimony of Michael Welner, M.D., Chairman of the Forensic Panel), available at http://www.forensicpanel.com/aboutus/pressroom/2003_04_08_texastestimony1.htm (last visited Oct. 11, 2004).
adaptive skills must occur before the eighteenth birthday. In contrast, the Texas statutory definition of mental retardation, as stated in the Texas Persons with Mental Retardation Act, and the Social Security Administration’s requirements for mental retardation as a disability require that the deficits occur during the developmental period. The Social Security Administration extends or cuts off the developmental period, depending upon individual perception, on the day prior to the person’s twenty-second birthday. Defining the developmental period in this manner gives rise to an argument as to the age when a particular individual offender had completed his/her developmental period. Indeed, some individual offenders might complete their developmental period before reaching their eighteenth birthday, while others might not complete their developmental period until they reach their nineteenth, twentieth, twenty-first, or twenty-second birthday.

19 Tex. Health & Safety Code Ann. § 591.003(13) (Vernon 2003). The Code defines “mental retardation” as “significantly subaverage general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.” Id.

20 Office of Disability Programs, Soc. Sec. Admin., Disability Evaluation Under Social Security § 12.05 (2003). Section 12.05, “Mental Retardation,” states: “Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22.” Id. Note that the scores specified below refer to those obtained on the Wechsler Adult Intelligence Scale (“WAIS”) and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning. Id.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.
A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded; or
B. A valid verbal, performance, or full scale IQ of 59 or less; or
C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function; or
D. A valid verbal, performance, or full scale IQ of 60 through 70, resulting in at least two of the following:
   1. Marked restriction of activities of daily living; or
   2. Marked difficulties in maintaining social functioning; or
   3. Marked deficiencies in maintaining concentration, persistence or pace; or
   4. Repeated episodes of decompensation, each of extended duration.


22 Office of Disability Programs, Soc. Sec. Admin., supra note 20, § 12.05.
When examined realistically, arbitrary age cutoffs and the term “developmental period” may not, as might be expected, include all those patients who are justifiably diagnosed as mentally retarded. Indeed, the diagnosis of mental retardation does not depend exclusively upon the age of the individual when the diagnosis of mental retardation is first considered, nor does the term “developmental period” act as an expression of a defined mentally retarded state. The use of a defined age limit and the term “developmental period” can be a double-edged sword, its cut depending upon the professional or the agency that wields it. The following two examples are helpful in understanding this concept.

1. The Case of Sue

Sue is 20 years old and married Bill against her overprotective parents’ advice and without their approval. Sue was in special education in school and was designated a slow learner. Sue had few friends and was often made fun of by the other children in her grammar school and junior high school. In addition, Sue’s parents remarked that she was naïve, had poor street survival skills, and unrealistically believed that Bill would care for and comfort her and would never ask or implicate her in any illegal activity. Unfortunately for Sue, Bill was heavily involved in pornography. He created an internet website where, for a fee, viewers could watch Bill having sex with Sue. Eventually, Bill brought up the subject of Sue having sex with a friend of Bill’s younger brother. After several months of cajoling, Sue gave in and had sex with a young man who turned out to be 16 years old. The young man’s mother found out and reported the incident to the police. Bill and Sue were arrested and Sue was charged with indecency with a child. The defense was able to establish that Sue met the criteria for mental retardation. Sue was tested and she scored a 66 on a standardized IQ test. Sue’s school records and interviews with teachers and family provided relevant information regarding her maladaptive behavior and poor coping skills, all of which were clearly identified as occurring before her eighteenth birthday.

In Sue’s case, though she was 20 years old at the time of the offense, the defense was able to prove by a preponderance of the evidence that she met the criteria for a person with mental retardation. For Sue, it made no difference whether the criteria for mental retardation used her eighteenth birthday or the term “developmental period.” Both definitions required the defense to look back into her past to develop a clear picture of her maladaptive behavior, the need for special education classes, and the reasonable assumption
that her present IQ score of 66 reflected her IQ prior to her eighteenth birthday.

2. The Case of Paul

Paul was big for his age, which he lied about in order to join the U.S. Army when he was 16 years old. Paul passed the physical examination and did well in basic training. Following basic training, Paul was sent to Fort Campbell in Kentucky. Paul, at 17, was a passenger in a car that was involved in a single car accident. Paul was not wearing a seat belt. He was thrown through the windshield, struck a tree and sustained a severe head injury. Paul suffered a skull fracture and a significant traumatic brain injury caused by a severe brain contusion with a subdural and subarachnoid hemorrhage. Paul was in a coma for two weeks, but survived. Rehabilitation was long and Paul was left with significant cognitive, behavioral, and personality deficits. Neurocognitive testing revealed an IQ score of 64 and Paul scored within the mental retardation range in adaptive behavior scales. Although Paul was almost 19 years old when the testing was done, medical experts testified to a reasonable degree of medical certainty that Paul would meet the criteria for mental retardation if he had been tested following the accident, which would have been prior to his eighteenth birthday.

Use of the term “developmental period,” rather than Paul’s eighteenth birthday, would make it more difficult for Paul to meet the criteria for mental retardation and to receive the benefits associated with this diagnosis. In Paul’s case, a very cogent argument could be made that he had completed the developmental period of his life when he joined the Army, performed well in basic training, adjusted to military life, and continued performing well up until the time of the accident.

B. The Gradation of Mental Retardation: Problems with Categorization

Mental retardation is broken down into the following categories: Mild Mental Retardation, Moderate Mental Retardation, Severe Mental Retardation, and Profound Mental Retardation.\textsuperscript{23} The above

\textsuperscript{23} DSM-IV, supra note 17, at 43.

MILD MENTAL RETARDATION (IQ 50–70) is roughly equivalent to what used to be referred to as the educational category of “educable.” This group constitutes the largest segment (85%) of those individuals with mental retardation. This group typically develops social and communication skills during the preschool years (ages 0–5 years), have minimal sensorimotor impairment, and often are not distinguishable from children with-
categories, as well as the required criteria for the diagnosis of mental retardation, are the creation of those professionals who work and toil in this field. In other words, mental retardation is a spectrum of disabilities related to varying degrees of abnormal brain function that affect an individual’s ability to understand, appreciate, adapt, and conform to the expectations of the community in which they live. The various categories are artificially created by professionals and agencies working with persons suffering from what is regarded as deficient brain function. Testing instruments were created in an attempt to provide some objectivity to a very subjective assessment process.\textsuperscript{24} In the assessment of individuals for mental retardation, the transition zones between categories produce the most debate, as these transition zones are not clear-cut.\textsuperscript{25} The most

out mental retardation until a later age. By late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

MILD MENTAL RETARDATION (IQ 55–69) is usually equivalent to what used to be referred to as the educational category of “educable.” This group constitutes about 10% of the entire population of people with Mental Retardation. Most of these individuals acquire communication skills during early childhood years. They might profit from vocational training and, with moderate supervision, can attend to their personal care. They may also benefit from training in social and occupational skills but are unlikely to progress beyond the second-grade level in academic subjects. During adolescence, their difficulties in recognizing social conventions may interfere with peer relationships. In their adult years, the majority are able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general workforce.

MILD TO MODERATE MENTAL RETARDATION (IQ 35–49) constitutes about 10% of the total population of people with Mental Retardation. Most of these individuals acquire communication skills during early childhood years. They might profit from vocational training and, with moderate supervision, can attend to their personal care. They may also benefit from training in social and occupational skills but are unlikely to progress beyond the second-grade level in academic subjects. During adolescence, their difficulties in recognizing social conventions may interfere with peer relationships. In their adult years, the majority are able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general workforce.

MODERATE MENTAL RETARDATION (IQ 35–40 to 50–55) is roughly equivalent to what used to be referred to as the educational category of “trainable.” This group constitutes about 10% of the entire population of people with Mental Retardation. Most of these individuals acquire communication skills during early childhood years. They might profit from vocational training and, with moderate supervision, can attend to their personal care. They may also benefit from training in social and occupational skills but are unlikely to progress beyond the second-grade level in academic subjects. During adolescence, their difficulties in recognizing social conventions may interfere with peer relationships. In their adult years, the majority are able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general workforce.

SEVERE MENTAL RETARDATION (IQ 20–25 to 35–40) constitutes 3% to 4% of individuals with mental retardation. During early childhood years, they acquire little or no communicative speech. During the school-age period, they may learn to talk and can be trained in elementary self-care skills. They profit to only a limited extent from instruction in pre-academic subjects, such as familiarity with the alphabet and simple counting, but can master skills such as learning sight reading of some “survival” words. In their adult years, they may be able to perform simple tasks in closely supervised settings. Most will adapt to live in the community in group homes or with their families.

PROFOUND MENTAL RETARDATION (IQ below 20 or 25) constitutes approximately 1% to 2% of people with mental retardation. Most individuals with this diagnosis have an identified neurological condition that accounts for their mental retardation. During the early childhood years, they display considerable impairments in sensorimotor functioning. Optimal development may occur in a highly structured environment with constant aid and supervision and an individualized relationship with a caregiver. Motor development and self-care and communication skills may improve if appropriate training is provided. Some can perform simple tasks in closely supervised and sheltered settings. Id.

\textsuperscript{24} AAMR, supra note 16, at 51–56.

\textsuperscript{25} See DSM-IV, supra notes 17, 23; see also Ofried Spreen & Esther Strauss, A Compendium of Neuropsychological Tests: Administration, Norms and Commentary 599–659 (2d ed. 1998).
important and critical transition zone occurs in the area between mild mental retardation and borderline intelligence. Following the Atkins decision, the criminal defense attorney in a capital murder case will be expected to perform the necessary legal investigation and work to move his/her client under the protective umbrella of mental retardation, whenever mental retardation might be a consideration.

1. Records and Tests Used in the Diagnosis of Mental Retardation

Records and tests are instrumental in assessing the potential for and degree of mental retardation in criminal defendants. Many health care records and measures will (or should) contain information addressing mental health issues, level of intelligence and adaptive behavior. Further, health related records addressing etiological factors that may result in or lead to the development of mental retardation should be addressed. Such factors may be biological, psychosocial, or a combination of both. These etiological factors may be divided into the following groups:

a. Hereditary:

May include genetic and chromosomal aberrations (Down’s syndrome, fragile X syndrome, Tay-Sachs disease, tuberous sclerosis, etc.).

b. Alterations of Embryonic Development:

May include chromosomal changes or prenatal damage due to toxins (maternal drug and alcohol consumption, in-utero infections, etc.).

c. Pregnancy and Perinatal Problems:

May include fetal malnutrition, prematurity, hypoxia, trauma, viral and other infections.


27 Id. at 374–82, 1001–02.
d. General Medical Conditions Acquired in Infancy and Childhood:

May include infections, traumas, and poisoning (e.g., due to lead).28

2. Environmental Influences and Other Mental Disorders:

May include deprivation of nurturance; deprivation of social, linguistic, and other needed stimulation; and severe mental disorders (e.g., Autistic Disorder).29

These factors should be assessed during testing. A review of health care records, including analysis by an expert if necessary, should also be performed.

Below, some of the more common and important tests are reviewed. The results of these tests and the information therein should be carefully reviewed by criminal defense attorneys to provide accurate and relevant information to determine the mental retardation status of their client.

28 Id. at 989–1005.
29 Id. at 235–70, 489–502.
3. Intelligence Quotient (IQ)\textsuperscript{30} Tests

a. The Wechsler Intelligence Scale for Children (WISC III)\textsuperscript{31}

This test is available for children ranging in age from six through sixteen.\textsuperscript{32} The IQ score is based upon verbal and performance tests.\textsuperscript{33} The results are recorded as Full Scale IQ with Verbal Scale IQ (VIQ) and Performance Scale IQ (PIQ).\textsuperscript{34} The performance of the individual is compared with the average scores attained by members of that person’s age group.\textsuperscript{35} The WISC is a collection of ten distinct core subtests and three supplemental subtests divided into verbal scales (six subtests) and performance scales (seven subtests).\textsuperscript{36} The five core subtests in each scale (verbal and performance) produce scale specific (VIQ and PIQ) IQs. These ten subtest

\textsuperscript{30} This section provides a brief overview of the most commonly utilized tests of intelligence and adaptive behaviors. For a more detailed understanding of these tests the reader is referred to the following materials. See Kaplan \& Sadock’s Comprehensive Textbook of Psychiatry 564 (Harold I. Kaplan \\& Benjamin J. Sadock eds., 6th ed. 1995) (“Intelligence [is] the ability to understand, recall, mobilize and constructively integrate previous learning in meeting new situations.”); Spreen \& Strauss, supra note 25, at 43 (“Intelligence test scores are converted to a scale in which the mean is 100 and the standard deviation (a measure of variability of the distribution of scores) is 15. About 95% of the population has scores within two standard deviations of the mean, that is, between 70 and 130.”); see generally R. Bar-On \& J. Parker, The Handbook of Emotional Intelligence Theory, Development, Assessment, and Applications at Home, School, and in the Workplace (2000); Child and Adolescent Psychiatry, supra note 26; J. Clements \& N. Martin, Assessing Behaviors Regarded as Problematic for People with Developmental Disabilities (2003); G. Groth-Marnot, Handbook of Psychologic Assessment (4th ed. 2003); A. Kaufman \& E. Lichtenberger, Essentials of WAIS-III Assessment (1999); A. Kaufman \& E. Lichtenberger, Essentials of WISC-III and WPPSI-R Assessment (2000); E. Lichtenberger \& A. Kaufman, Essentials of WPPSI-III Assessment (2003); J. Satler, Assessment of Children: Cognitive Applications (4th ed. 2003); J. Clements \& N. Martin, Assessing Behaviors Regarded as Problematic for People with Developmental Disabilities (2003).

\textsuperscript{31} See generally Spreen \& Strauss, supra note 25, at 90–129. The norms for the WISC-III were based on a standardization sample of 2,200 children from the United States. AAMR, supra note 16, at 60. The Wechsler Intelligence scales are sold through The Psychological Corporation. These tests are only permitted in the hands of fully licensed or certified psychologists, so that the tests remain valid and reliable, in the authors’ opinion.

\textsuperscript{32} Spreen \& Strauss, supra note 25, at 91.

\textsuperscript{33} Id.

\textsuperscript{34} Id.

\textsuperscript{35} Id. at 103. Ninety-five percent of children tested will score within two standard deviations (one standard deviation = 15) from the mean (mean = 100); in other words, between 70 and 130. Id. Their cohorts below 70 and above 130 make up the remaining 5%. Id. The children below 70 comprise 2 to 2.5% of the population. Id.

\textsuperscript{36} AAMR, supra note 16, at 60–61; Spreen \& Strauss, supra note 25, at 90–92.
scores then produce the Full Scale IQ. Some believe the WISC-III has greater reliability than the Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R) because there is less emphasis on speed. As noted below, the WPPSI-R was created to test children of a young age (three to seven years old), which is a difficult undertaking, especially considering the caution necessary when predicting intelligence based on test results.

**b. The Wechsler Preschool and Primary Scale of Intelligence – Revised (WPPSI-R)**

This test is available for children ranging in age from three to seven. Reading and writing are not required. The WPPSI-R contains twelve subtests including object assembly, geometric design, block design, mazes, picture completion, animal pegs, information, comprehension, arithmetic, vocabulary, similarities, and sentences. Although the materials, test items, and directions were selected for their suitability for young children, some of the concepts may be difficult for low functioning individuals to understand (e.g., geometric design, similarities, vocabulary, etc.). In such cases, other tests, such as Stanford-Binet or Kaufman-ABC, may be preferred.

In terms of validity, the Wechsler IQ shows substantial correlation with other measures of intelligence and with academic achievement. Two basic factors are identified for the Wechsler tests, the verbal comprehension factor and the perceptual organization factor.

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37 Scren & Strauss, supra note 25, at 90–92.
38 Id. at 92.
40 See generally Scren & Strauss, supra note 25, at 90–124.
41 Id. at 91.
42 Id. at 91–92.
43 Id.
44 Id. at 90–129; AAMR, supra note 16, at 51–71; see also Harcourt Assessment, Inc., at http://harcourtassessment.com/haiweb/Cultures/en-US/Psych+Community/Psychological.htm (offering links discussing various tests offered).
45 Scren & Strauss, supra note 25, at 91–92, 141–52.
46 Id. at 98.
47 Id.
The verbal comprehension factor

This measures verbal knowledge and comprehension, which reflects the application of verbal skills to novel situations.\textsuperscript{48}

The perceptual organization factor

This involves perceptual and organizational dimensions, which reflects the ability to interpret and organize visually perceived material within a specified time limit. This factor has correlated well with visuospatial ability/memory, visual attention, and executive function.\textsuperscript{49}

Only an unusually large discrepancy between the VIQ and the PIQ can be used to support a diagnosis of an abnormality indicating the need for further evaluation.\textsuperscript{50} It is important to understand that it is not uncommon for normal individuals to demonstrate significant VIQ/PIQ differences, and hence any abnormal score should be the basis for further testing rather than any substantive conclusions.\textsuperscript{51}

Clinicians have attempted to identify patterns of test performances typical of specific brain-damaged groups.\textsuperscript{52} However, the identification of characteristic profiles has proved to be difficult. Though patients with unilateral left hemisphere disease obtain lower VIQ than PIQ scores, these abnormalities, and others, do not occur with a regularity necessary to establish adequate clinical reliability.\textsuperscript{53} In addition, as noted above, significant differences between VIQ and PIQ are quite common among normal people, and these discrepancies vary as a function of education and the Full Scale IQ.\textsuperscript{54}

The Wechsler tests have been disappointing in detecting poor effort or faked poor intelligence except for excessive failures on easy items and grossly absurd or illogical responses. The individual with normal intelligence who is either not making an effort or is deliber-

\textsuperscript{48} See supra note 25, at 101.

\textsuperscript{49} See supra note 25, at 101.

\textsuperscript{50} Id.

\textsuperscript{51} Id. Interpretation of the VIQ/PIQ discrepancy requires a determination of the significance of the difference (these are noted and identified in the Wechsler manuals). Id. If the difference is determined to be meaningful, it is necessary to determine how unusual the difference is in the normal population. Id. Large VIQ/PIQ discrepancies are more typical for individuals with high Full Scale IQs (or high educational levels) than those with relatively low IQs (or low educational level). Id.

\textsuperscript{52} See supra note 25, at 101.

\textsuperscript{53} Id.

\textsuperscript{54} Id.
ately attempting to do poorly would rarely make absurd or illogical responses.56

Test scatter results can provide valuable information about an individual’s cognitive strengths and weaknesses, along with suggestions for possible remediation.56

c. Kaufman Assessment Battery for Children (K-ABC)57

This test is available for children ranging in age from 2.5 to 12.5 years.58 There are sixteen subtests that are grouped into a mental processing set and an achievement set.59 Six of the ten mental processing subtests are considered “nonverbal” and, therefore, especially suited for children with communication handicaps.60 The K-ABC was based on a theoretical model of a sequential and simultaneous information processing dichotomy.61 One of the ten mental processing subtests seven are labeled simultaneous and three sequential.62

d. Stanford-Binet Intelligence Scale-Revised (SBIS-R)63

This test is available for children ranging in age from two to eighteen years.64 The Stanford-Binet has been around for many years.65 It has gone through many updates and remains a reliable

55 See id. at 102.
56 See id. at 109. Test scatter refers to scores on subtests within the overall intelligence test.
Id. Some tests have a greater reliability (Information, Vocabulary, and Block Design) than others (Object Assembly, Picture Arrangement, Mazes and Symbol Search). Id. The least reliable of the subtests will have the largest standard errors of measurement. Id. Thus, though test scatter results can be helpful in identifying areas of deficiency the clinician must be careful in interpreting relative cognitive strengths or weaknesses on the basis of a single subtest that has relatively poor reliability. Id.
57 Id. at 141–147; AAMR, supra note 16, at 63–64.
58 Spress & Strausse, supra note 25, at 141.
59 See generally id. at 141–42.
60 Id. at 141.
61 Id.
62 Id. at 141–43. Though the K-ABC is based upon a theoretical orientation and thus purported to break down into a left (analytic-sequential) and right (gestalt-holistic-simultaneous) hemisphere function, there is little evidence that it actually validates the neuropsychological implications of the sequential-simultaneous (left/right hemisphere) dimension. Id.
63 See generally id. at 147–52.
64 Id. at 147.
65 Id. at 147; AAMR, supra note 16, at 62.
IQ test. The Stanford-Binet groups items into fifteen subtests covering four broad areas—verbal reasoning, abstract/visual reasoning, quantitative reasoning, and short-term memory.

All intelligence test scores have a ±3 to 5 point standard error of measurement. Thus, IQ scores within the 65–75 range could identify an individual with either borderline intelligence or mild mental retardation. The IQ score alone is not determinative of mental retardation. In addition, an individual’s adaptive behaviors as expressed in conceptual, social, and practical adaptive skills are important criteria in identifying those with mental retardation.

4. Tests of Adaptive Behavior and Personality

In addition to tests relating to mental retardation and intelligence, it is important to note that behavior and personality represent essential factors in assessment of the potentially mentally retarded criminal defendant. It is essential that criminal defense attorneys not limit their evaluation to intelligence levels when presenting their clients as mentally retarded.

For these purposes, the Vineland Adaptive Behavior Scales (VABS), the Scales of Independent Behavior-Revised (AIB-R), the AAMR Adaptive Behavior Scales (ABS), and the Comprehensive Test of Adaptive Behavior-Revised (CTAB-R), are among the most widely used adaptive behavior assessments in the United States. Their popularity is owed largely to their usefulness and accuracy, derived from quality standardization and norming.

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66 AAMR, supra note 16, at 51–71; Spreen & Strauss, supra note 25, at 147.
67 See Spreen & Strauss, supra note 25, at 147.
69 Since an IQ of 70 is two standard deviations below the mean and since IQ tests have a ±3 to 5 standard error of measurement, then IQ scores from 65 to 75 are not diagnostic in regards to the cognitive arm of mental retardation. See AAMR, supra note 16, at 57, 67–71; Spreen & Strauss, supra note 25, at 43.
70 The importance of adaptive behavior is stressed in all recent definitions of mental retardation, which require significantly subnormal functioning in both intelligence and adaptive behavior. Spreen & Strauss, supra note 25, at 599.
71 See AAMR, supra note 16, at 73–76; Spreen & Strauss, supra note 25, at 599.
72 See generally Spreen & Strauss, supra note 25, at 599.
73 AAMR, supra note 16, at 77.
74 "Standardization is the process of developing a test that reliably and validly measures a specific dimension of behavior." Brad Hill, Adaptive and Maladaptive Behavior Scales (2001) at http://www.cpinternet.com/∼bhill/icap/compare.htm (modified July 12, 2004). This process involves trying out items in testing circumstances and analyzing them; "revising and discarding those that don’t work"; adding items where there are problems; and re-
Adaptive behaviors are everyday living skills such as walking, talking, getting dressed, going to school, going to work, preparing a meal, cleaning the house or one’s room, etc. Since adaptive behaviors are for the most part developmental, it is possible to describe a person’s adaptive behavior as an age equivalent score. Behavior problems or maladaptive behaviors are behaviors that interfere with everyday activities. Good adaptive behaviors promote independence at home, at school, and in the community. Behavior problems are usually not developmental and their expression varies from day to day and from setting to setting.

The purpose of employing the behavior and personality scales is to assess the individual’s social and personal adaptive abilities in daily living and to formulate diagnoses and/or program planning. The diagnosis of mental retardation requires deficits in both cognitive ability and adaptive behavior occurring before age eighteen. Adaptive behavior assessment is used to determine the type and amount of special assistance that people with disabilities might need. Correlation of adaptive behavior and intelligence are related but separate constructs.

a. Vineland Adaptive Behavior Scales (VABS)

The purpose in all the behavior scales, as noted above, is to assess the social and personal adaptive abilities of the individual in daily living, together with the formulation of diagnoses and/or program planning.

analysing the results. ld. Ultimately, the test should measure the same thing the same way each time, so that the scores are comparable. ld. In addition, the “test score should correlate with some recognized behavior in the real world.” ld.

“Norming is the process of determining average scores for average people.” ld. Norming requires testing hundreds or thousands of carefully selected individuals (e.g., schoolchildren), in order to give a single child’s score meaning, i.e., something to compare the individual score to. ld. A score of 7 has more meaning when that score is at the 50th percentile for children of a certain age. ld.

ld.

75 See generally Spreen & Strauss, supra note 25, at 599–659.
76 Id. AAMR, supra note 16, at 79.
77 ld. at 14, 24–25, 73–75.
78 See Atkins, 536 U.S. at 308 n.3 (citing American Association on Mental Retardation and American Psychiatric Association definitions).
79 AAMR, supra note 16, at 83.
80 See generally Spreen & Strauss, supra note 25, at 656–59.
The VABS survey consists of 297 items (an expanded form includes an additional 280 items), which are presented to the primary caretaker in a semi-structured interview. The survey is not administered directly to the subject but rather to the person most familiar with him or her, and asks questions regarding the subject’s functionality. Items cover four domains:

1. Communicative
   a. receptive
   b. expressive
   c. written
2. Daily Living Skills
   a. personal
   b. domestic
   c. community
3. Socialization
   a. interpersonal
   b. play and leisure time
   c. coping skills
4. Motor Skills
   a. gross motor skills
   b. fine motor skills

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83 Id. at 656–57.
84 Id. at 656–59.
85 Communicative skills involve the higher brain centers, which are involved in the ability to understand and appreciate information delivered via the five senses and responding appropriately to that input. Expressive communication, in part, describes a person’s ability to speak in goal directed and logical sentences and to write integrated paragraphs and sentences. Receptive communication involves the use of all the senses to understand what is seen and heard. In evaluating children with communicative deficits, it is imperative to discover causes for deficits such as blindness, deafness and dyslexia in children with normal intelligence. CHILD AND ADOLESCENT PSYCHIATRY, supra note 26, at 191–202.
86 Daily living skills involve feeding oneself, bathing, dressing, grooming, and control of bowel and bladder. In addition, daily living skills have to do with the child’s ability to get along with his/her parents and siblings, and how the child adapts to the routine of the home. AAMR, supra note 16, at 73–91.
87 Social skills measure the child’s socialization and interpersonal skill, such as cooperation, awareness and consideration of others, participation in group activities, initiation of play, and sharing with others. Other areas evaluated are the child’s ability to conform to the activity of the social group, emotional stability, demanding excessive attention, etc. CHILD AND ADOLESCENT PSYCHIATRY, supra note 26, at 902–08; see also Spreen & Strauss, supra note 25, at 599–601.
88 If motor skill deficits are present, the child should be evaluated by a pediatric neurologist. The gross motor skills survey evaluates the child’s ability to walk, problems with balance, and episodes of unexplained falling. Fine motor skills surveys evaluate the child’s ability to write, draw, and hold objects such as crayons, pencils, forks and spoons, etc. CHILD AND ADOLESCENT PSYCHIATRY, supra note 26, at 444–47.
An optional set of items covers maladaptive behaviors, such as bedwetting, inappropriate impulsiveness, crying or laughing. An expanded form of the VABS is designed to serve as a systematic basis for preparing educational, habilitative, and treatment programs.

b. Scales of Independent Behavior (SIB-R)

The SIB-R contains an excellent behavior problem scale in addition to its adaptive behavior assessment. It provides a unique score that reflects overall independence based on adaptive and maladaptive behavior combined. It can be administered either as a questionnaire or as a carefully structured interview, and includes special materials designed to aid the interview process. It has a short form for children and a short form adapted for the blind. It includes scales on social interaction and community skills, personal living skills, and community living skills. A fourth score, i.e., motor skills, can contribute information about the health dimension of the child’s overall individual functioning.

c. AAMR Adaptive Behavior Scale 2nd Edition (AAMR ABS)

The ABS is available in two forms: one for school, and one for residential and community settings. Both versions assess how individuals cope with natural and social demands of their environ-

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89 See SPRESEN & STRauss, supra note 25, at 656–59. These are behaviors not specific to the mentally retarded child; however, they are behaviors that can be acquired by the child with mental retardation similar to their acquisition by children of normal mentality. Id.
90 Id. Specific deficit areas are identified, providing information that is helpful in developing a program to assist and encourage the child in developing positive coping mechanisms and adaptive behaviors. Id.
91 See generally AAMR, supra note 16, at 89.
93 Id.
95 AAMR, supra note 16, at 89.
96 Id.
97 See generally id. at 88.
98 Id.
The school version is used to identify students whose adaptive behavior functioning is significantly below that of their peers, and to assess the effects of intervention programs. The residential and community section relates to problem behaviors that cause problems for the child outside of the school environment.

d. Inventory for Client and Agency Planning (ICAP)

The ICAP is "a sixteen-page booklet that assesses adaptive and maladaptive behavior and gathers additional information to determine the type and amount of special assistance that children with disabilities may need." The ICAP can be completed by a parent, teacher, or careperson who is well acquainted with the child being assessed. In addition to measuring adaptive and maladaptive behavior, the ICAP gathers a compact but comprehensive set of information about the individual's demographic characteristics, diagnoses, support services needed and received, and any factors that limit social/leisure activities.

The ICAP's adaptive and maladaptive behavior sections contain items selected from the SIB-R with norms for infants through adults. Like the SIB-R, the ICAP yields a service score, which is a combined measure of adaptive and maladaptive behavior indicative of overall need for care, supervision, or training. The ICAP is useful on three levels: for individualized planning, for program management, and for statewide statistic keeping.

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99 There has been criticism of the ABS in regards to the unidimensional scale on several domains. For example, the ABS Physical Development Domain score is difficult to interpret because items on balance, walking, running, and arm-hand use, are scored together with items on vision and hearing. See Hill, supra note 74.

100 AAMR, supra note 16, at 88.

101 Id.


103 Id.

104 Id.

105 Id.

106 Id.

107 Id.

108 Id.; see also Spreen & Strauss, supra note 25, at 43.
5. Other Records, Reports, and Data

Other information may also be useful to the criminal defense attorney in determining whether his or her client is mentally retarded. Although tests and scales provide a quantum of information to be considered, there are numerous other records, reports, and data that can be very helpful in providing an overall picture and assessment of the individual’s behavior and functioning.

a. Pregnancy Records

Medical records from the mother’s pregnancy and amniocentesis results, if available, can add to the understanding of prenatal difficulties. Here, one is looking to determine the mother’s health during pregnancy; whether she used alcohol or drugs, and whether she suffered any significant illness or traumas. Perinatal records at the time of delivery, especially fetal heart monitoring tapes during the mother’s labor, might elicit information regarding fetal distress during delivery.

b. Birth Records

Birth records with APGAR scores and assessment notes by doctors and nurses provide information as to the baby’s overall health during the early post-delivery period.

c. Pediatric Records

The records of the child’s pediatrician usually include growth charts, which measure weight, height, and head circumference. In addition, there will normally be a list of any congenital anomalies or abnormalities, and there may also be DNA test results. Mothers often keep a scrapbook indicating when the child met various milestones. This information is often included by the pediatrician in the child’s health records.


110 Id. at 502–10; Nelson Textbook of Pediatrics, supra note 109, at 536–47.

d. Informational Diary

A diary with information regarding the child, kept by the mother and/or family members, may be useful and should always be requested. Particularly if the child has had problems since birth, his or her pediatrician may have recommended that the mother keep a diary regarding the child’s milestones and behavior.

e. School Records

School records will contain information whether the child attended special education classes, and the results of psychological evaluations, if such evaluations were done. The Social Security Administration’s School Activity Report and Mental Disorders Evaluation is a source of important information regarding the child’s progress and behavior in school.112 These can provide significant insights into adaptive and maladaptive behavior and provide a historical perspective on the subject.

f. Hospital Records

If a child has been hospitalized, hospital records should be reviewed. A child’s mental state and adaptive behavior might have changed following a serious illness or trauma.113 Trauma records are especially important when they are associated with injuries to the head and episodes of hypoxia (e.g., near drowning). Suicide attempts that cause significant trauma or hypoxia might provide important information either causing or exacerbating a child’s low IQ and/or maladaptive behaviors.

g. Substance Abuse Records

A child’s history and records of substance abuse, such as glue and other volatile substance sniffing/huffing, psychedelic substances, PCP (phenycyclidine), and other substances, provide very important and useful information, especially when the child intentionally or unintentionally overdoses on these substances, requiring hospitalization.

113 Child and Adolescent Psychiatry, supra note 26, at 363–74.
h. State Records

The Texas Department of Mental Health and Mental Retardation’s (TDMHMR) county and regional facilities, for example, are a source of records that should be obtained and reviewed. The mental retardation division of the Texas Department of Criminal Justice may also be a source of records and important data.

The above is intended to be a non-inclusive list of records, reports, and data that might help to provide a comprehensive picture of the individual, and rational explanations as to why he or she should be considered a person who meets the state criteria for mental retardation. However, it is imperative to seek out any additional records, reports, and data that may provide similar information; asking family, state juvenile authorities, and medical personnel familiar with the subject is essential so as to ensure full and complete assessment of all relevant information to reach an accurate assessment of the mental status of the client.

III. Policy Ramifications

Fifteen years ago, in 

*Penry v. Lynaugh*, Justice O’Connor noted at the outset that the Court would be deciding two important issues, i.e., “whether petitioner, Johnny Paul Penry, was sentenced to death in violation of the Eighth Amendment because the jury was not instructed that it could consider and give effect to his mitigating evidence in imposing its sentence . . . [and] . . . whether the Eighth Amendment categorically prohibits Penry’s execution because he is mentally retarded.”

The Court held that the Eighth Amendment did not preclude the execution of a mentally retarded person. The Court’s decision in *Atkins* has overturned that part of the *Penry I* holding. Of significant importance, however, was the Court’s reasoning in *Penry I*, which was reiterated in *Penry II* regarding in-

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114 *Penry I*, 492 U.S. at 307.

115 Id. at 340 (“In sum, mental retardation is a factor that may well lessen defendant’s culpability for a capital offense. But we cannot conclude today that the Eighth Amendment precludes the execution of any mentally retarded person of Penry’s ability convicted of a capital offense simply by virtue of his or her mental retardation alone.”).

116 See *Atkins*, 536 U.S. at 321 (“Our independent evaluation of the issue reveals no reason to disagree with the judgment of the legislatures that have recently addressed the matter and concluded that death is not a suitable punishment for a mentally retarded criminal.” (internal quotations omitted)).

structions to the jury that would allow the jury to consider and give effect to mitigating evidence in imposing its sentence.\textsuperscript{118}

Over the thirteen years between \textit{Penry I} and \textit{Atkins}, the Court found that evolving standards of decency, public sentiment, and contemporary values toward mental retardation as expressed in legislation enacted by the country’s legislatures clearly indicated that a substantive change had occurred.\textsuperscript{119} The \textit{Atkins} Court noted that the evolving standards of decency now required the Eighth Amendment to be construed and applied in light of these changes, so that the Constitution placed ""a substantive restriction on the State’s power to take the life’ of a mentally retarded offender.""\textsuperscript{120}

\textit{Penry I} and \textit{Penry II} are also applicable to the severely mentally ill, especially those suffering with severe psychotic disorders. The argument here is that the defendant in the throes of a severe psychotic mental disorder at the time the crime was committed is less culpable as the perpetrator of such a crime than one who was in a normal mental state. In crimes committed by defendants with severe psychotic disorders where the prosecutor seeks the death penalty, the defense attorney ought to request the \textit{Penry} jury instruction during the punishment phase, if the insanity defense was not successful. In non-death penalty cases, defense attorneys whose clients are either mentally retarded or seriously mentally ill must be extremely cautious when deciding whether or not to include testimony of experts to mitigate punishment. As Justice O’Connor noted in \textit{Penry I}, Penry’s mental retardation and history of abuse could be used as double-edged swords.\textsuperscript{121}

\textit{Atkins} and \textit{Penry} provide important guidance for defense attorneys representing mentally retarded clients in criminal cases. In death penalty cases, the strategy is to prove that the defendant meets accepted criteria for mental retardation. In this arena, the greatest debate will focus on those defendants who fall within the mildly mentally retarded category, as this category lends itself to reasonable dispute.\textsuperscript{122} Supplemental information and evidence, as noted above, in addition to standard testing and evaluations, are


\textsuperscript{119} \textit{Penry I}, 492 U.S. at 335, 336; \textit{Atkins}, 536 U.S. at 310, 328.

\textsuperscript{120} \textit{Atkins}, 536 U.S. at 321 (quoting Ford v. Wainwright, 477 U.S. at 405).

\textsuperscript{121} \textit{Penry I}, 492 U.S. at 324 (observing that ""[i]t may diminish his blameworthiness for his crime even as it indicates that there is a probability that he will be dangerous in the future").

\textsuperscript{122} \textit{Atkins}, 536 U.S. at 317–18 (""To the extent there is serious disagreement about the execution of mentally retarded offenders, it is in determining which offenders are in fact retarded.").
paramount if mental retardation is to be proven in the mildly mentally retarded defendant.

In death penalty cases, defense attorneys representing defendants with mental retardation face another important strategic decision, i.e., whether they should plead the affirmative defense of insanity. If the defendant’s mental retardation is well documented, the defense attorney must be familiar with current Not Guilty by Reason of Insanity (NGRI) case law in his or her state in order to make a reasonable assessment as to whether the defendant’s interests will be better served by incarceration in the state hospital system or in the state penitentiary. The issue is whether the circumstances of the crime are such that the defendant would stand a better chance of being released from the prison system sometime in the future than being released from the state hospital system. As noted below, this evaluation by the defense attorney becomes much more critical in crimes of lesser magnitude.

In non-death penalty criminal cases, defense strategy depends upon a well-reasoned risk/benefit analysis in the use of the defendant’s mental retardation or severe mental illness as either mitigation in the punishment phase of the criminal hearing or in pleading insanity during the guilt/innocence phase of the trial. In Connecticut, for example, NGRI acquitees often spend more time incarcerated in state hospitals than they would if they had been convicted of their crime and sent to prison. In 1985, Connecticut established the Psychiatric Security Review Board (PSRB). The PSRB is an autonomous body whose primary concern is the protection of soci-

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123 Texas law provides:

(a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong.

(b) The term “mental disease or defect” does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct. Tex. Penal Code Ann. § 8.01 (Vernon 2003).

124 See, e.g., Tex. Code Crim. Proc. Ann. art. 37.021(2)(B) (Vernon 2003) (“Under the law applicable in this case, if the defendant is sentenced to imprisonment in the institutional division of the Texas Department of Criminal Justice for life, the defendant will become eligible for release on parole, but not until the actual time served by the defendant equals 40 years, without consideration of any good conduct time.”).

125 Personal communication with Howard V. Zonana, M.D., Professor of Psychiatry, Yale School of Medicine; Medical Director, American Academy of Psychiatry and the Law (February 7, 2003).

Allegedly, this board has been especially reticent to find that the NGRI acquittee no longer poses a risk to the community. Though focused on a relatively small group of death penalty defendants, Atkins is a potent harbinger of future Supreme Court decisions. Justice Scalia’s dissent provides a clear interpretation of the Court’s Atkins decision. Justice Scalia recounts our long jurisprudential history in finding “idiots” and “lunatics” as enjoying a special status under the law because of their lack of reason and understanding or their inability to distinguish between good and evil. Offenders with less severe impairments suffered criminal prosecution and punishment, including capital punishment. Thus, according to Justice Scalia, the Court in Atkins carved out a special category for the mildly mentally retarded and provided these defendants with the same dispensation previously set aside for “idiots” and “lunatics” i.e., severe and profoundly mentally retarded persons.

Justice Stevens’ majority opinion provides opportunities for defense attorneys in death penalty cases to argue for diminished culpability when representing not only defendants with mental retardation, but also defendants with severe mental illness. The Court noted that the mildly mentally retarded exhibit “disabilities in areas of reasoning, judgment, and control of their impulses,” and “they do not act with the level of moral culpability that characterizes the most serious adult criminal conduct. Moreover, their impairments can jeopardize the reliability and fairness of capital proceedings against mentally retarded defendants.”

Justice Stevens notes that a claim of excessive punishment is judged by the standards that currently prevail, and the most reliable

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128 Personal communication with Howard V. Zonana, M.D., supra note 125.

129 Atkins, 536 U.S. at 337-54.

130 Id. at 340.

131 Id. at 340-41.

132 Id.

133 See Atkins, 536 U.S. at 315-16. ("The large number of States prohibiting the execution of mentally retarded persons ... provides powerful evidence that today our society views mentally retarded offenders as categorically less culpable than the average criminal." This provides an opportunity for defense attorneys to argue that the defendant suffering severe mental disease or defect at the time of the criminal act was “categorically less culpable than the average criminal."). Id. at 316.

134 Id. at 306-07.
evidence of contemporary values lies in the legislation enacted by the country's legislatures. Justice Stevens questions whether retribution or deterrence provides a justification for executing mentally retarded defendants.

Atkins opens the door for these same arguments to be brought forward in death penalty cases involving the mentally ill, rather than only the mentally retarded, who at the time of the alleged crime were in the throes of their psychosis. Though the defendant's psychotic episode may not rise to the level where an insanity defense is reasonable, it is, nevertheless, reasonable to argue that his or her psychosis affects the defendant's ability to think, reason, judge, and control his or her impulses. Sometime in the future, the Court might agree that defendants who commit capital crimes in the throes of their psychosis "exhibit disabilities in areas of reasoning, judgment, and control of their impulses," and "they do not act with the level of moral culpability that characterizes the most serious adult criminal conduct. Moreover, their impairments can jeopardize the reliability and fairness of capital proceedings against mentally retarded defendants." In addition, someday in the not too distant future, the Court may find that "evolving standards of decency," public sentiment, and contemporary values regarding severe mental illness indicate that these impairments could jeopardize the reliability and fairness of capital proceedings against defendants with severe mental illness.

The mentally ill defendant who commits a death penalty offense while psychotic is often at a disadvantage when compared to the mentally retarded defendant, since the psychotic defendant's mental illness is often treatable. In addition, the same double-edged sword noted in Penry also hangs over the head of the seriously mentally ill offender. Nevertheless, the Atkins Court provided ample material to consider in defining and protecting those persons who commit heinous criminal acts, but due to their mental deficits are seen as less culpable than those defendants without such deficits. The Atkins Court, in accepting the challenge brought before it by a maturing society, has chosen to advance the notion that there are those unfortunate individuals among us, who because of significant

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135 Id. at 312.
136 Id. at 318–19.
137 Atkins, 536 U.S. at 306–07.
138 Id. at 322.
139 See Penry I, 492 U.S. at 324.
deficits in the very attributes that make us human, also make them less culpable.\textsuperscript{140}

IV. Conclusion

For those with mental illness, the activities and vagaries of life are often difficult and may lead to unacceptable social behaviors, resulting in the commission of illegal acts with subsequent criminal prosecution. The United States Supreme Court in \textit{Atkins} established that there must be significant analysis of the mental disorders affecting these defendants to deal with them justly and judge them on the basis of the moral culpability appropriate for their level of function. Criminal defense attorneys representing these defendants therefore have a moral duty to investigate the substantive measures of competence, behavior, and activities to outline the sometimes unclear borders of mental illness. We have provided a brief overview of the tests and information that criminal defense attorneys may, and should, assess in making these determinations, and the ramifications of the \textit{Atkins} case on future defendants with mental illness. It is imperative that these defendants have informed counsel on these matters, and that policymakers understand what may result from the \textit{Atkins} decision. These defendants are some of the most vulnerable members of our society, and the accurate determination of their mental status is literally a life and death matter for them, of which they have little understanding or control. We, as a society, must ensure that these individuals are rightly evaluated and represented, because in the future, we will be judged on how we have treated our most powerless members. How we treat our mentally ill is hence the conscience of our criminal justice system, and we should ensure that we maintain its clarity by fully understanding what must be done to ensure their rights are protected.

\textsuperscript{140} The Texas Court of Criminal Appeals has addressed the constitutional ban in \textit{Atkins} against the death penalty for those with mental retardation. See, e.g., \textit{Ex parte Simpson}, 136 S.W.3d 660 (Tex. Crim. App. 2004); \textit{Ex Parte Briseno}, 135 S.W.3d 1 (Tex. Crim. App. 2004).