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Mental Retardation and the Death Penalty: The Clinical and Legal Legacy

References

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AN OBVIOUS CULTURAL lag long existing between the United States and its European and North American allies surrounds the death penalty. The 2002 U.S. Supreme Court ruling, *Atkins v. Virginia*, finally outlawed the practice of "death qualifying" mentally retarded (MR) offenders, a practice long abandoned by other democracies. And, more recently, in March 2005, the high court banned the death penalty for juvenile offenders (*Roper v. Simmons*). While the death penalty is no longer an option within the European Union and it is not practiced in either of our border NAFTA neighbors (Mexico and Canada), executing the mentally retarded, the mentally ill, and youth is seen as especially uncharacteristic of civilized societies, especially in light of the current research on the neurophysiology and neuro-psychology of the central nervous system (CNS) and its relationship to the measure of adult-level competency—the very foundations of culpability. The advent of more advanced neuro-imaging techniques within the past 20 years has led to a better understanding of brain development, notably in children and youth. Generally speaking, hormonal infusion and rapid growth spurts during puberty, coupled with incomplete frontal lobe mylenation (neuronal insulation), creates a likelihood of both increased subcortical impulses and insufficient frontal lobe control over these impulses. And while the process of frontal lobe mylenation is usually complete at the time skeletal growth is completed (usually age 18 in Western societies) it takes another seven years for sufficient pathways to be etched in the Basal Ganglia (neuronal super highway). This phenomenon accounts for the higher incident of impulsive behaviors among youth and adults until age 25. This is the current argument against "death qualifying" youth (French & deOca, 2001). The mentally retarded, on the other hand, have diminished cognitive capacity due to birth defects or accidents and brain insults prior to the age of 18. Unlike adolescents, the mentally retarded are not likely to ever correct their status of diminished responsibility. This fact has long been recognized, leading to the well-intended but ill-fated sterilization laws enacted in much of the U.S. during the 20 th century.

Ironically, while clinical disciplines, including psychology, have made significant contributions to the current MR and juvenile offender cases before the high court, they have also contributed historically to the now questionable practices of eugenics, a foundation for the most severe societal sanction—the death penalty for mentally retarded offenders. Interestingly, the U.S. Supreme Court based its death penalty decisions not on international consensus but rather on "national consensus." But once this means test was met, the Court used clinical evidence to support its ban on "death qualifying" the mentally retarded. The current foundation for the June 2002 U.S. Supreme Court decision (*Atkins v. Virginia*) is rooted in the new neurological research available within the past 15 years and represented by current clinical assessment tools, including

the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).

The *Atkins* decision reads: "Execution of criminals who were mentally retarded held to constitute cruel and unusual punishment in violation of Federal Constitution's Eighth Amendment." Essentially the Court felt that the execution of the mentally retarded would not measurably contribute to either deterrence or retribution within the U.S. criminal justice system. The Court also noted that mentally retarded defendants face a greater risk of wrongful execution before the judicial system and therefore warrant special protection. In *Atkins*, the U.S. Supreme Court noted that the evolving standards of decency within the country now prohibit the execution of people who are mentally retarded. The scientific basis for this decision cites the standards set forth by both the American Association on Mental Retardation (AAMR) and the American Psychiatric Association that MR is basically defined as 1) significant subaverage general intellectual functioning, 2) concurrent with deficits in adaptive functioning, and 3) occurring before age 18.

Clearly the introduction of clinical elements in the death penalty argument is significant—but not new. Even then, jurisdictions such as Texas continue to defy *Atkins* by challenging the clinical definition of mental retardation, bringing to the forefront the marked, and often contravening, differences between the legal and mental health disciplines and their respective definitions of the situation. Contributing to this dilemma concerning a concise measure of mental retardation are the conflicting definitions offered by two separate organizations: the American Association on Mental Retardation (AAMR) and the American Psychiatric Association (APA). In *Atkins* the U.S. Supreme Court used the 1992 AAMR definition:

> Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18 (Luckasson, 1992:5).

The American Psychiatric Association definition that is listed in the DSM-IV-TR offers variable IQ ranges for each of the four categories, while also noting that MR has numerous etiologies (presented on Axis III) and: "may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system (APA, 2000: 41-49)." Here, Mild Mental Retardation, one of five codes within the MR classification diagnosis, is listed as an IQ range of 50 to 55 to approximately 70. Accordingly, a seventy IQ reflects two standard deviations from the normative IQ of 100 or a statistically significant departure from the norm as stated in the Atkins decision. Texas continues to challenge the measurement of the IQ range requisite for a diagnosis of mental retardation in its attempt to continue to death qualify offenders with low-range intelligence.

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Clinical/Legal History of Assessing Legal Competence

The role of psychology in the classification of intelligence, and hence legal competence, goes back to the origin of intelligence measurement itself—the Binet Simon developed in France in the early 1900s by psychologist Alfred Binet and physician Theodore Simon (Fancher, 1985). However, it was the U.S. version—the Stanford-Binet—that made dramatic claims relevant to its power to predict deviant and/or criminal behaviors, hence paving the way for legal sanctions directed toward those labeled "subaverage." Terman stated in the original 1916 Stanford-Binet that:

> It is safe to predict that in the near future intelligence tests will bring tens of thousands of these high-grade defectives under the surveillance and protection of society. This will ultimately result in curtailing the reproduction of feeble-mindedness and in the elimination of an enormous amount of crime, pauperism and industrial inefficiency…. One of the most important facts brought to light by

> the intelligence test is the frequent association of delinquency and mental deficiency…. There is no investigator who denies the fearful role played by mental deficiency in the production of crime, vice and delinquency…. Not all criminals are feeble-minded, but all feeble-minded are at least potential criminals. That every feeble-minded woman is a potential prostitute would hardly be disputed by anyone…. Considering the tremendous cost of vice and crime it is evident that psychological testing has found here one of its richest applications (Terman, 1916:26).

Clearly, Terman was influenced by British psychologist Francis Galton, who was in fact his mentor. Galton, considered the father of scientific psychology and mentor to J.M. Cattell, Spearman, and Terman, played a significant role in setting the stage for the use of psychological tests to implement the dictates of Social Darwinism. These ideals were born in Galton's theory of eugenics (breeding for positive traits). Eugenics, implemented partly through involuntary sterilization, was seen as the means for achieving successful Social Darwinism in the United States. The purpose was simple—improvement of the human race through the elimination of what were considered to be defective gene pools. It was Terman, however, who provided the seemingly objective measure for determining who was unfit.

To Terman, general intelligence testing provided sufficient evidence to evaluate and label serious deviants in society. Included here was the implicit plan for social control, including the elimination of the mentally deficient through institutionalization and sterilization. Indeed, the influence of Galton's eugenics coupled with Terman's U.S. version of the Binet was so profound that by 1926, 23 states had enacted mental retardation sterilization laws, 18 of those providing for mandatory sterilization of those classified as being mentally deficient, including habitual criminals. In 1927, the U.S. Supreme Court upheld involuntary sterilization in *Buck v. Bell*. A recent study by faculty at Johns Hopkins University compares eugenic sterilization in both the United States and Germany from 1930 until 1945. While the numbers of U.S. forced sterilizations pale in comparison with the 360,000 to 375,000 affected by this practice during Nazi rule (this number not including those exterminated during the Holocaust), some 40,000 persons were involuntarily sterilized in America during this period (Sofair & Kaldjian, 2000). Involuntary sterilization ended in the United States, at both the state and federal levels, during the Civil Rights era of the 1960s, when it was realized that those most likely to be subjected to this practice were poor minorities, notably African Americans and Native Americans (French, 1994).

The race/class and IQ controversy continued into the 1970s and 1980s with the *Larry P. v. Riles* case. The *Larry P.* challenge, filed in 1971, was a class-action suit representing African-American children and youth labeled as being EMR (educable mentally retarded) by the San Francisco Public Schools and subsequently placed in special education classes. The suit claimed that flawed IQ assessments resulted in a disproportionate number of minority children being placed in "educable mentally retarded classes." The petitioners contended that this process violates Title IV of the 1964 Civil Rights Act, the 1973 Rehabilitation Act, and Public Law 94-142—the 1975 Education for All Handicapped Children Act (EAHCA of 1975). One of the petitioners, the Bay Area Association of Black Psychologists, sought a ban on IQ testing, especially single measure indicators of general intelligence. The Association argued that existing IQ tests were not adequately standardized to reflect minority subcultures in the United States, hence resulting in these students having a greater likelihood of being placed in stigmatizing special education curriculum that, in turn, led to a greater school drop-out rate and a marked disadvantage in the job market once they left school. French (1986a) noted that the mechanism of testing stigma is tantamount to *blaming the victim*, a self-fulfilling prophecy whereby minorities, including the mentally retarded, are blamed for their poor test results and therefore become labeled as deviant.

The *Larry P.* case worked its way through the California courts and into the federal appeals courts, ending with the Circuit Court of Appeals in 1984. The result was an agreement that no assessment of ability would rest on a single instrument. Equally compelling was the move to better norm subsequent versions of existing instruments as well as to include other measures of

mental retardation, such as medical etiologies, life histories and the like in order to rule out class, ethnic, and racial factors (French, 1986a, 1986b, 1986c).

Another factor leading to the execution of the mentally retarded was the movement toward deinstitutionalization that began in the 1960s with the advent of new psychotropic medications and the movement toward community mental health facilities. Interestingly, the deinstitutionalization process in the United States was initiated in the prisons (*Baxstrom v. Herald*, 1966; *Dixon v. Attorney General of the Commonwealth of Pennsylvania*, 1971) and only later involved facilities for the mentally retarded (*Wyatt v. Stickney*,1972; *Halderman v. Pennhurst*, 1979). Two major U.S. Supreme Court cases occurred in the 1980s—*Youngberg v. Romeo*, 1982; and *City of Cleburne v. Cleburne Living Center*, 1985)—setting the stage for the current U.S. Supreme Court decision. Additionally, the *Larry P. v. Rile* case challenged the reliability and validity of intelligence testing, especially among minorities challenging Terman's faith in the ultimate power of IQ tests. Even then the Atkins ruling allows the state to determine how mentally retarded offenders are to be assessed and measured. Part of this dilemma can be traced to the fact that *Larry P. v. Riles* was not appealed to the U.S. Supreme Court.

In *Baxstrom v. Herold*, the high Court held that Baxstrom had been denied equal protection of the law by statutory procedures under which he was held at New York's Dannemora State Hospital for the criminally insane. Deemed mentally ill while serving a criminal sentence, Baxstrom was held beyond the expiration of his maximum sentence. The U.S. Supreme Court ruled that this action and corresponding statutory justification violated Baxstrom's civil rights, notably those guaranteed under the Fourteenth Amendment, as well as those of the entire class that his case represented. This case was significant in establishing three precedents for the rights of the incarcerated mentally ill: 1) it terminated the practice of extended institutionalization; 2) it established a critical precedent regarding both prisoners' and patients' rights; and 3) it forced the immediate transfer of nearly a thousand patients from penal to civil facilities (French, 1986d; Steadman & Keveles, 1972).

While *Baxstrom* initiated the decarceration process within forensic facilities, it was the Dixon case (*Dixon v. Attorney General of the Commonwealth of Pennsylvania*) that addressed the issue of dangerousness—the single most critical factor used in determining long-term institutionalization, whether in a prison forensic unit, psychiatric ward or state school. Here, Donald Dixon and others filed a class action suit challenging the constitutionality of their involuntary confinement at Pennsylvania's Farview State Hospital. In 1971, the Court ruled for the plaintiffs, ordering all members of the Dixon class either released outright or reevaluated for treatment in non-forensic mental health facilities. Similarly, the *Dixon* case required that sentence-expired mentally ill offenders must be released from penal forensic institutions to civil facilities or to the community (French, 1986d; Thornberry & Jacory, 1979).

The 1971 *Wyatt v. Stickney* case specifically addressed the rights of involuntarily confined mentally retarded clients. The federal Court in this case ruled for improved standards of institutional operations for the mentally retarded in Alabama. While this case did not call for the release of the institutionalized class of mentally retarded residents, it did specify the "quality of care" required for these involuntarily committed individuals, thereby setting the stage for eventual deinstitutionalization of this population. The conditions now required included: 1) a humane environment; 2) sufficient and qualified staff; 3) individualized treatment plans; and 4) residence in the least restrictive environment (Braddock, 1981).

In 1977, in *Halderman v. Pennhurst*, a federal Court ordered the first closing of a U.S. mental health facility. In its decision, the Court determined that confinement and isolation of retarded residents at the Pennhurst State School constituted segregation. Moreover, the Court cited the state school for not abiding to the minimal treatment standards set out in *Wyatt*. The state of Pennsylvania appealed the decision all the way to the U.S. Supreme Court, setting the stage for the 1982 Youngberg decision.

Both the *Youngberg* and *Cleburne* cases had unintended consequences that unwittingly fueled the mentally retarded death penalty controversy in addition to their manifest intent of improving the

lives of the mentally retarded population in the United States. The *Youngberg* case was significant in that the U.S. Supreme Court based this decision on lower court rulings and in contrast to its 1926 Buck v. Bell decision sanctioning eugenics via sterilization of the mentally retarded. The *Youngberg* case addressed the *Wyatt 71, 72, 74* standards relevant to the involuntary confinement of the mentally retarded. In *Youngberg* the U.S. Supreme Court nationalized these standards across the country.

Essentially the U.S. Supreme Court looked at the case of Nicholas Romeo, an involuntary resident of Pennhurst State School and Hospital, relevant to his Fourteenth Amendment rights. The Court held that involuntarily committed mentally retarded residents have a constitutional right to habilitation and training. Indeed, the U.S. Supreme Court explicitly stated that involuntarily committed persons afflicted with mental retardation have the same rights to due process as do prison inmates, including habeas corpus petitions: “If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed—who may not be punished at all—in unsafe conditions” (*Youngberg v. Romeo*: 1982).

The *Youngberg* decision states that mentally disabled people cannot be deprived of the following interests that are clearly recognized as constitutionally required for institutional care:

1. Reasonable care and safety.
2. Freedom from bodily restraints.
3. Adequate food, shelter, clothing, and medical care.
4. Those liberty interests to which convicted criminals are entitled.
5. Adequate training or habilitation to ensure the enjoyment of liberty.

The *Youngberg* ruling touched upon a number of critical clinical and legal areas affecting both institutional care (quality of care; habilitation and treatment; aftercare) and community placement (mainstreaming into public group homes). Many states found it too expensive to maintain their state schools and psychiatric hospitals under these conditions, resulting in the release of significant numbers of mentally retarded and mentally ill (MI) clients into communities that were ill-prepared for the intensity of their care. Ironically, prisons and jails now became the home of inadequately treated MR and dual diagnosed MR/MI individuals. The clinical safety net was not adequate at that time and still is deficient in many states, leading to long backlogs of never-treated mentally retarded individuals, making them all the more susceptible to criminal adjudication (French, 1983; 1986d).

Community resistance to group homes led to the second major U.S. Supreme Court decision regarding the care of the MR. In the 1985 *City of Cleburne v. Cleburne Living Center* case, the Court ruled that mental retardation in itself does not determine a quasi-suspect class and therefore does not warrant special legal rights beyond those afforded all citizens under the Equal Protection Clause of the Fourteenth Amendment. By the same token, the Court struck down zoning ordinances that may discriminate against group homes for mentally retarded clients. This ruling proved to be a mixed blessing for advocates of deinstitutionalization. While the ruling removed a serious obstacle to strategically located group homes for this population, it also denied these mainstreamed clients additional special considerations that may have been available if they were afforded “quasi-suspect” classification, such as is extended to the mentally ill. A major consequence of this ruling was the changing of mental retardation from an Axis I major clinical syndrome to Axis II, beginning with the 1987 Diagnostic and Statistical Manual (DSM-III-R) and in all subsequent versions.

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The DSM and the Criminal Adjudication Process

Axis I disorders, with the exception of the v-codes, offer defendants substantial license regarding mitigating circumstances. This is especially critical in the two-phase adjudication process articulated in the U.S. Supreme Court’s reinstatement of the death penalty in 1976, following its

1972 *Furman v. Georgia* ruling on the death sentence as being unconstitutional as administered up to that time (*Gregg v. Georgia*; *Jurek v. Texas*; *Proffit v. Florida*). The advent of the DSM-III in 1980 greatly aided forensic psychology and psychiatry by providing a scientific multi-axle model of clinical definitions based on the World Health Organization's International Classifications of Diseases (ICD). This provided for a more objective marriage between the clinical and legal disciplines in civil, criminal and juvenile court hearings with the generally accepted understanding that Axis I major clinical disorders and/or syndromes could be presented as mitigating circumstances in order to challenge aggravating circumstances. On the other hand, it was generally held that Axis II disorders were not to be considered significant factors that could override aggravating circumstances. At the time of the DSM-III, personality disorders were the only category in Axis II.

But following the U.S. Supreme Court's 1985 *Cleburne* decision that the mentally retarded did not share the same special protected class as the mentally ill, MR classifications were relegated to Axis II, beginning with the 1987 DSM-III-R. This shift in classification now made mentally retarded defendants "death qualified" even under the two-tier adjudication death qualifying system approved by the U.S. Supreme Court and used from 1976 until the present. It would be interesting to know how many, if any, MR defendants were spared being "death qualified" between 1976 and 1985. At any rate, the resulting separation of the MR class from the same legal protection held by the mentally ill (MI) class was seen by many as an unfortunate unintended consequence of the *Cleburne* decision.

Nonetheless, the 2002 *Atkins* ruling set the stage for the next death qualifying legal challenge, that of death qualifying youth offenders. All other *civilized* nations, including international organizations such as the United Nations and the European Union, were already against the execution of adolescents. The December 2003 issue of the *American Psychologist* addressed this issue as well. Laurence Steinberg and Elizabeth Scott, in their article, "Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty," presented many of the same clinical and neuro-physiological issues that were offered in the clinical defense against executing the MR—mainly that neither class should be held to the normal adult standard of *mens rea*, especially when considering the ultimate sanction—execution:

> Under principles of criminal law, culpability is mitigated when the actor's decision-making capacity is diminished, when the criminal act was coerced, or when the act was out of character. The authors argue that juveniles should not be held to the same standards of criminal responsibility as adults, because adolescents' decision-making capacity is diminished, they are less able to resist coercive influence, and their character is still undergoing change. The uniqueness of immaturity as a mitigating condition argues for a commitment to a legal environment under which most youths are dealt with in a separate justice system and none eligible for capital punishment (Steinberg & Scott, 2003: 1009).

The American Psychological Association filed an amicus brief in the *Roper v. Simmons* case before the U.S. Supreme Court. The brief supported banning the death penalty for youth, presenting recent psychological research that indicates that youth are more impulsive and take more risks than adults, make more immature decisions, fail to resist peer influence and are more susceptible to coercion and false confessions: "The brief includes recent brain-imaging research on brain functioning that suggests an average brain continues to develop through the teen years, particularly in areas that control decision-making (Gilfoyle, 2005: 46)." Clearly, as the Supreme Court ultimately agreed in *Roper v. Simmons*, the arguments for diminished capacity also apply to the mentally retarded and youth. There is clear scientific evidence that these classes of individuals do not have the same mental resources and capacity as adults when it comes to full criminal responsibility—the standard which provides the basis for mens rea and hence the justification for society's ultimate sanction—death.

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