



OPENING THE DOOR:

JUSTICE FOR ADULT DEFENDANTS WITH MENTAL RETARDATION

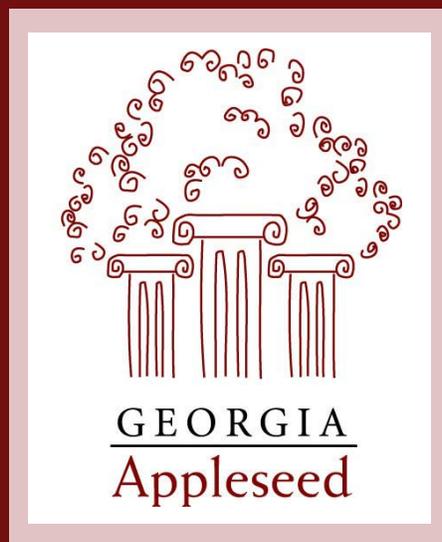
A Handbook For Attorneys
Practicing in Georgia



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Sowing the Seeds of Justice throughout Georgia



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OPENING THE DOOR: JUSTICE FOR ADULT DEFENDANTS WITH MENTAL RETARDATION

A HANDBOOK FOR ATTORNEYS PRACTICING IN GEORGIA

Georgia Appleseed



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Georgia Appleseed

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"To listen to the unheard voices of the poor, the children, the marginalized; to uncover and end the injustices that we would not endure ourselves; to win the battles for our constituency in the courts of public opinion or in the halls of justice that no one else is willing or able to fight."

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Georgia Appleseed presents the information in this handbook as a service to attorneys who represent defendants with mental retardation. While we worked to provide accurate and up-to-date information, this handbook is not intended to provide legal advice. Non-lawyers should seek the advice of a licensed attorney in all legal matters. Georgia Appleseed makes no warranties, express or implied, concerning the information contained in this handbook or other resources to which it cites.

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ABOUT THIS HANDBOOK

About This Handbook – The Georgia Edition

When Georgia Appleseed opened its doors in late 2005, it already knew that it would be looking often to its well-regarded sister center in Texas to learn how to do Appleseed work “right.” Little did we know in 2005 that in September 2007 the primary author of the first edition of this handbook, Deborah Fowler, would be a featured speaker at a conference to be held in Atlanta and sponsored by many of the leading social service agencies in Georgia serving people with developmental and intellectual disabilities. With Deborah’s participation in the conference, it made sense to do the important work of converting the first edition of *Opening the Door*, originally based on Texas law, into a Georgia law edition. Under the experienced hand of Georgia Appleseed Law Fellow Sonia Bell-Nichols, a professional editor in her life before entering Mercer University’s Walter F. George School of Law, and with the generous contributions of time and expertise of the members of our revision team identified earlier, the result you hold in your hands is one that remains true to the goals of the first edition – the ongoing effort to improve legal representation for criminal defendants who have intellectual disabilities – with an eye towards how justice is to be done in Georgia.

About This Handbook – The Texas Edition

Texas Appleseed issued its *Fair Defense Report: Analysis of Indigent Defense Practices* in Texas five years ago. Our work to assess the condition of indigent persons in the criminal justice system revealed the special needs of defendants with mental retardation and the inadequate representation they often receive. Defense attorneys, like other court officials, often fail to recognize mental retardation. Even when attorneys recognize clients as having mental retardation, many attorneys are not familiar with the special procedures and laws that apply to persons with mental retardation. Lack of knowledge can be compounded by the client’s desire to get out of jail quickly. Together, these factors may result in a defendant pleading guilty to an alleged offense when he or she is not competent to do so. When an intellectual disability impairs the defendant’s ability to understand what is happening to him or her or to participate in his or her own defense, it is imperative that attorneys and court personnel are well-versed in the special procedures that exist to divert vulnerable clients away from the criminal justice system.

The *Fair Defense Report* revealed many other shortcomings in the treatment and representation of defendants with mental retardation. Except in death penalty cases, attorneys rarely request and courts rarely appoint mental retardation experts. Many attorneys lack expertise in finding, evaluating, and questioning experts; at the same time, few credible and impartial experts are available to conduct evaluations. As a result, attorneys may not use experts to advocate for their clients in critical areas such as mitigation and sentencing. The general lack of understanding of mental retardation and habilitation options contributes significantly to harsher sentences, longer stays in jail, and frequent revocations of probation for defendants with mental retardation.

This handbook is part of Texas Appleseed’s ongoing effort to improve legal representation for criminal defendants who have mental retardation. It was developed and reviewed by experts in intellectual disabilities and attorneys experienced in criminal law. However, it is not a comprehensive guide on the law pertaining to mental retardation or on how to represent defendants with intellectual disabilities. Attorneys should use this work as a starting point for their work with adult clients who have mental retardation. We hope it will alert attorneys to some basic legal options they may want to consider, and give them some ideas about where to go for assistance.

We encourage attorneys who represent defendants with mental retardation to go the extra mile for their clients. It could make all the difference.



A NOTE ABOUT THE LANGUAGE

Although *mental retardation* is still used as a diagnostic label, the term is currently considered to be hurtful and stigmatizing to those to whom it has been assigned. In recognition of this, the term *intellectual disability* is now being used to refer to the condition historically called *mental retardation*. State and federal agencies and national organizations are removing the older term from their names, and the term *intellectual disability* is being used for research and publication.

While the *term mental retardation* is still sometimes required for diagnostic or legal purposes, use of the term should be limited. In keeping with the requests of men and women with disabilities and in reflection of current respectful language, attorneys should use the term *intellectual disability* whenever possible when they counsel clients and family members of clients with an *intellectual disability*. However, *mental retardation* is still the legal term used in the statutes that govern the Georgia criminal justice system. Therefore, the term *mental retardation* will be used in this handbook.***

TOP TEN THINGS TO KEEP IN MIND AS YOU REPRESENT A CLIENT WITH MENTAL RETARDATION.

- 1. IF YOUR CLIENT HAS MENTAL RETARDATION, HE OR SHE MAY TRY TO “MASK” THE DISABILITY:** As a result, law enforcement, judges, and even you may have difficulty identifying your client as a person with mental retardation. If you suspect your client has mental retardation, investigate further. Do not rely solely on the client’s assurance to the contrary.
- 2. INDIVIDUALS WITH MENTAL RETARDATION ARE VULNERABLE AT EVERY STAGE IN THE CRIMINAL JUSTICE SYSTEM:** This means that it is particularly important for you to consider your client’s disability at each point of the client’s contact with the system, from his or her ability to understand Miranda warnings to his or her competence to stand trial. You should be familiar with the unique characteristics that some persons with mental retardation share, which increase the potential for an inequitable outcome.
- 3. IF YOUR CLIENT IS INCOMPETENT, STOP AND SEEK AN EVALUATION:** A client who is incompetent may not be able to make informed decisions about fundamental issues, such as whether or not to enter into a plea bargain agreement or, instead, proceed to trial. Do not allow a client who you have reason to believe is incompetent accept a plea bargain, or make any other decisions regarding the case. Instead, immediately request a competence evaluation.
- 4. FIND THE RIGHT EXPERT(S):** It is important that you find someone who has substantial experience in working with clients with mental retardation. Most psychologists and psychiatrists do not have this training or experience. You should not assume that someone who is qualified to work with clients who have a mental illness is also qualified to work with your client.
- 5. REMEMBER THAT DIAGNOSIS INVOLVES MORE THAN JUST A LOW SCORE ON AN IQ TEST:** Determining whether a person has mental retardation has three components: a score on an IQ test that is 70 or below (taking the standard error of measurement into account), deficits in adaptive behavior, and manifestation during the developmental period. Do not focus solely on IQ scores when you are attempting to

*** For more information about the definition and application of the terms intellectual disability and mental retardation, please visit the website of the American Association on Intellectual and Developmental Disabilities (AAIDD) at <http://www.aamr.org>.

determine whether your client may have mental retardation.

6. **MITIGATE, MITIGATE, MITIGATE:** Mental conditions that inspire compassion, without justifying or excusing the crime, can be powerful mitigation evidence. Part of your job as an attorney is to present the judge or jury with evidence that reveals your client as someone with significant impairments and disabilities that limit the client's reasoning or judgment. Mitigation evidence can be used to argue for a shorter term of incarceration or for probation instead of incarceration.
7. **OVERCOME YOUR OWN PREJUDICES BEFORE YOU HURT YOUR CLIENT'S CASE:** There are many stereotypes surrounding mental retardation that can be harmful to your client. It is important for you to examine your own misconceptions so that you can be an effective advocate for your client. Representing a person with mental retardation is not only an opportunity to help the person you represent – it is an opportunity for you to educate the judge, jury, prosecutor, and probation officer about mental retardation. Be a responsible advocate, not only for your client, but also for others with mental retardation who must navigate the criminal justice system after your client's case is resolved.
8. **INCARCERATION IS PARTICULARLY HARMFUL TO INDIVIDUALS WITH MENTAL RETARDATION:** Offenders with mental retardation are more likely than others to be victimized by other inmates or jail staff. They also have difficulty understanding and following prison rules and schedules. This means that offenders with mental retardation may spend more time in jail due to disciplinary infractions. If possible, try to get your client's case dismissed quickly and, where appropriate, try to get your client released on bond. Determine whether the county has instituted a jail diversion program that could help your client avoid incarceration.
9. **DO NOT LET YOUR CLIENT GET CAUGHT IN THE "REVOLVING DOOR":** Many adults with mental retardation are arrested for minor offenses that directly relate to their disability or their poverty. Criminals often use them as scapegoats or "lookouts." They may cycle repeatedly through the courts and jails, charged with the same petty offenses. This "revolving door" is not only a burden to the courts and the criminal justice system, but it is costly to society, to these individuals, and to their families. By quickly pleading your client to "time served" without exploring the client's disability, you may lose the opportunity to help your client get needed services that will help him or her avoid trouble. It is equally important to get your client out of jail as soon as possible and to keep him or her from returning to jail. Releasing persons with mental retardation back into the community with no plan for services or support is a recipe for revocation and recidivism. Don't set up your client to fail.
10. **YOU OWE YOUR CLIENT A ZEALOUS REPRESENTATION:** You have the ethical obligation to zealously represent your client, which may include exploring your client's case for issues related to the disability. It may also include bringing appropriate motions if your client's mental retardation has affected the case in any of the ways discussed in this handbook. You should be aware that the failure to request appointment or otherwise obtain the assistance of qualified mental retardation experts when indicated can be a violation of your client's Sixth Amendment right to effective assistance of counsel.



SECTION 1

WHAT IS MENTAL RETARDATION AND WHY SHOULD YOU CARE?

WHAT IS MENTAL RETARDATION?

“Mental retardation” is a developmental disability that generally refers to substantial limitations in a person’s present levels of functioning.¹ These limitations may be manifested by:

- Delayed intellectual growth;
- Inappropriate or immature reactions to one’s environment; and
- Below average performance in academic, psychological, physical, linguistic, and social domains.²

In the Georgia criminal justice system, mental retardation means, “significantly subaverage general intellectual functioning resulting in or associated with impairments in adaptive behavior which manifested during the developmental period.”³ Mental health experts who work in the field of developmental disability and specialize in the diagnosis of mental retardation can provide guidance about this definition to attorneys who represent clients with mental retardation.

Although mental retardation is a legal term in the Georgia criminal justice system, mental health care professionals and others who advocate for persons with mental retardation prefer the term intellectual disability. The Georgia Department of Education (DOE) defines intellectual disability as “significantly subaverage general intellectual functioning which exists concurrently with deficits in adaptive behavior that adversely affect educational performance and is manifested during the developmental period.”⁴ The DOE describes the three essential elements of intellectual disability in its administrative rules.⁵

You may need to enlist the help of a mental health care provider to determine whether your client is a person with mental retardation. Mental health experts who work with clients with mental retardation are likely to use definitions that have been adopted by professional organizations such as the American Psychiatric Association (APA). The Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR), published by the APA, defines the three diagnostic components of mental retardation as follows:

1. Significantly subaverage intellectual functioning (IQ of approximately 70 or below on individually administered test);
2. 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.

¹ Mary Beirne-Smith, James R. Patton & Shannon H. Kim, *Mental Retardation* 40 (7th ed. 2006). As you represent clients with mental retardation, keep in mind that advocates for people with mental retardation are moving away from using the term “mental retardation” and replacing it with “intellectual disability.” The new term reflects respect for those with the disability. When you are advocating on behalf of your clients, the best practice might be to use the term “intellectual disability” when possible. However, keep in mind that the term mental retardation is also a legal term.

² *Id.*

³ Ga. Code Ann. §§ 17-7-131 (2007), 37-4-2 (2002); see Section 11 of this handbook for more information about the definitions of mental retardation, IQ tests, and assessment of adaptive behavior.

⁴ Ga. Comp. R. & Regs. r. 160-4-7-.05 Appendix (e) (as amended, effective date July 1, 2007).

⁵ *Id.*

3. Onset before age 18.⁶ (You should note that other sources suggest the developmental period is not complete until a person's early 20's).⁷

“MENTAL RETARDATION” IS NOT A “MENTAL ILLNESS”

Many people confuse mental retardation and mental illness.⁸ Mental retardation is not the same condition as mental illness. Mental retardation is distinguished from mental illness in a number of ways:

- Mental retardation is not an illness.
- Individuals with mental illness encounter disturbances in their thought processes and emotions, while persons with mental retardation simply have a limited ability to learn and process information.
- Mental illness is often temporary, while mental retardation is usually a lifelong disability. There is no “cure” for mental retardation.⁹

However, there are many individuals with mental retardation who also suffer from some type of mental illness. This is often referred to as a “dual diagnosis,” which is covered in Section 5 of this handbook.

DETERMINING MENTAL RETARDATION

IQ Tests

The American Association on Intellectual and Developmental Disabilities (AAIDD), formerly known as the American Association on Mental Retardation (AAMR), defines intelligence in its comprehensive reference book on intellectual disability. This text, known by professionals and laypersons as the AAMR, defines intelligence as “a general mental ability [that] includes reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, learning quickly, and learning from experience.”¹⁰ The assessment of intellectual functioning is one element of diagnosing mental retardation.¹¹

A score on an IQ test is an essential component of assessing intellectual functioning for purposes of a determination of mental retardation, but should not be used in isolation. It is generally agreed that a full-scale IQ of 70 or below satisfies the requirement of “subaverage intellectual functioning.”¹² The majority of people in the U.S. score between 80 and 120 on IQ tests, with an IQ of 100 considered average.¹³ Scoring below 70 on an IQ test places a person in the bottom 2 percent of the American population.¹⁴

⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 46 (4th ed., text revision 2000).

⁷ Richard Burr et al., *A Practitioner's Guide to Defending Capital Clients Who Have Mental Retardation* 10 n. 4 (2004).

⁸ See James W. Ellis & Ruth A. Luckasson, *Symposium on the ABA Criminal Justice Mental Health Standards: Mentally Retarded Criminal Defendants*, 53 Geo. Wash. L. Rev. 414, 423-24 (1985).

⁹ The Arc of New Jersey, *Defendants with Mental Retardation: A Guide for Attorneys* 6 (1996).

¹⁰ Ruth Luckasson et al., *Mental Retardation: Definition, Classification, and Systems of Supports* 51 (10th ed., AAMR 2002). (Note: AAIDD has recently published a companion guide to this reference book, see *Users Guide: Mental Retardation, Definition, Classification and Systems of Supports*, -10th edition (AAIDD 2007).

¹¹ *Id.*

¹² Burr et al., *supra* note 7, at 8.

¹³ Human Rights Watch, *Mental Retardation: an Overview*, in *Beyond Reason: The Death Penalty and Offenders with Mental Retardation* (2001), available at www.hrw.org/reports/2001/ustat (last visited June 8, 2007).

¹⁴ For a full discussion of IQ testing, see Section 11 of this handbook.

Because IQ tests are not considered to be absolutely accurate, a “standard error of measurement” (SEM) is taken into account when interpreting a score. Generally speaking, the conventional SEM is a range of plus or minus five points.¹⁵ This means that a score of up to 75 may still make a person eligible for a determination of mental retardation. Accordingly, a person’s IQ is not represented by a specific number; rather, scientists profess to be 95.5 percent confident that his or her IQ falls within a range of plus or minus 5 points on either side of the “full scale” test score.¹⁶

Measuring Adaptive Behavior

Adaptive behavior describes the way that people care for themselves and relate to others in the course of daily living. The acquisition of adaptive skills for most people is continuous and occurs naturally, but can be difficult for persons with mental retardation.¹⁷

The AAMR defines adaptive behavior as “the collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives.”¹⁸ Representative skills for each area include the following:

- **Conceptual skills** – language, reading and writing, money concepts, and self-direction.
- **Social skills** – interpersonal skills, responsibility, self-esteem, gullibility, naiveté, ability to follow rules, obey laws and avoid victimization.
- **Practical skills** – activities of daily living, occupational skills, and the maintenance of a safe environment.

Persons with mental retardation rarely have deficits in each area of adaptive behavior – in fact, limitations and strengths can often be found within the same domain.¹⁹

Adaptive behavior and intelligence are related and complementary concepts, but they are not the same.²⁰ While adaptive behavior and intelligence share much in common, they differ in several ways.

- Adaptive behavior measures focus on a person’s usual actions, whereas intelligence tests obtain information about maximal performance.
- Adaptive behavior measures examine how people care for themselves and relate to others as part of everyday living, whereas intelligence tests focus only on higher-order reasoning abilities.
- Intelligence tests are given under controlled conditions, while information about adaptive behavior is usually obtained through interviews with third parties.²¹

A number of standardized instruments exist for measuring adaptive behavior. However, if your client was not assessed before turning 18 years old, your knowledge in this area will also be based on information from other sources, including interviews with people who have known your client over the course of the client's life. A structured

¹⁵ Burr et al., *supra* note 7, at 8.

¹⁶ AAMR, *supra* note 10, at 59.

¹⁷ Beirne-Smith et al., *supra* note 1, at 105.

¹⁸ AAMR, *supra* note 10, at 73.

¹⁹ Burr et al., *supra* note 7, at 9.

²⁰ Beirne-Smith et al., *supra* note 1, at 109.

²¹ *Id.*

interview with the defendant and family members or friends, combined with a review of pre-incarceration social history and institutional adjustment, can provide a measure of adaptive behavior.²²

Onset Before Age 18

Mental retardation is a developmental disability whereby onset must have occurred before the age of 18. This does not mean that mental retardation must be diagnosed prior to age 18. Rather, the person must have exhibited limitations in adaptive functioning before the age of 18, and IQ testing (before or after age 18) must reliably establish an IQ of 75 or below (taking the highest SEM into account). You must also be able to show that there was no intervening reason for the person's intellectual or adaptive behavior functioning to have diminished since the age of 18.²³

If your client's mental retardation is going to play a role in your defense, you need to have a good understanding of the process for determining mental retardation.

Section 11 includes a more thorough discussion of definitions, evaluations, and problems associated with making determinations of mental retardation.

MISCONCEPTIONS ABOUT MENTAL RETARDATION

There are a number of misconceptions and stereotypes of mental retardation that you must guard against if you are advocating for a client with mental retardation. Some of these are listed below.

- **Misconception 1:** *All individuals with mental retardation are the same.* Persons with mental retardation, like all people, are complex human beings with unique and individualized strengths and limitations.
- **Misconception 2:** *Individuals who have mental retardation are more likely to commit crimes.* Though it is generally true that individuals with mental retardation are over-represented in the criminal justice system, this is most likely due to the way that they are treated at various stages of the criminal justice process, including contact with police officers and lawyers, the legal process more generally, and the prison experience.²⁴
- **Misconception 3:** *"Mild" mental retardation does not significantly impact a person's life.* Even "mild" mental retardation constitutes a substantial disability. An IQ in the 60 to 70 range is approximately the scholastic equivalent to the third grade.²⁵ In fact, the AAMR discarded the "mild-moderate-severe-profound" classification system because of its concern that "mild mental retardation" was incorrectly viewed as something less than a condition that represents a considerable disadvantage.²⁶
- **Misconception 4:** *Individuals with mental retardation "look" a certain way.* Persons with mild mental retardation often go undetected in screening and processing after arrest. Many people with mental retardation cannot be identified by their physical appearance alone.²⁷

²² Jane Nelson Hall, *Correctional Services for Inmates with Mental Retardation*, in *The Criminal Justice System and Mental Retardation* 167, 175 (Ronald W. Conley et al., eds. 1992).

²³ Burr et al., *supra* note 7, at 10.

²⁴ Criminology Research Centre, Simon Fraser University, Occasional Paper #2003-01, *Developmental Disability, Crime, and Criminal Justice: A Literature Review* 30 (2003); see also Ellis & Luckasson, *supra* note 8, at 426-27.

²⁵ Human Rights Watch, *supra* note 13, at 1.

²⁶ AAMR, *supra* note 10, at 26.

²⁷ Human Rights Watch, *supra* note 13, at 4.

- **Misconception 5:** *You can tell if someone is a person with mental retardation by observing that person's ability to do certain things.* For example, if a person can plan an activity or read, that person must not have mental retardation. It is generally a person's difficulty with a task that identifies someone as a person with mental retardation, not the person's ability to do certain things.²⁸ Not all individuals with mental retardation will display each of the characteristics associated with mental retardation.²⁹ Individuals with mental retardation, like everyone, will have strengths as well as weaknesses.
- **Misconception 6:** *Mental retardation is determined simply by looking at scores on IQ tests.* IQ tests are but one of the measures used to reach a determination of mental retardation. Measurement of adaptive behavior and age of onset are also considered.³⁰

It is important for us to consider that our own biases, as well as those of the police, court officials, and prosecution, can play a role in the way that persons with mental retardation are treated in the criminal justice system. Ruth Luckasson, J.D.,³¹ an authority on the barriers that individuals with mental retardation experience, created a list of the "reasons" that she had heard prosecutors, defense attorneys, and judges give to support their claim that a defendant did not have mental retardation.

"He can't possibly [have mental retardation]...

- Because he doesn't drool."
- Because you can see how normal he looks."
- Because he's so big."
- Because he's so mean."
- Because he played cards with the police officers who [brought] him over in the van, and one day he won."
- Because he can write."
- Because he can draw."
- Because he can do some things better than other things."
- Because no one knows it."
- Because I asked him and he said he's not, and he started crying."
- Because I talked to his family and they all denied it."
- Because I can talk to him easily. He's one of my favorite clients. He does everything I want him to."
- Because he tried to cover up his involvement in the crime."
- Because I know he's mentally ill."
- Because he talks so much."
- Because I saw in his file that ten years ago someone gave him an (unidentified) IQ test, and he had an IQ of 86."
- Because he can drive a car."
- Because we know he's competent to stand trial."
- Because he knows right from wrong."
- Because he's so street smart."

²⁸ See Burr et al., *supra* note 7, at 9.

²⁹ See Beirne-Smith et al., *supra* note 1, at 290.

³⁰ See AAMR *supra* note 10, at 16-17.

³¹ Ruth Luckasson, J.D., is a Regents Professor and she chairs the Department of Educational Specialties in the Department of Education at the University of New Mexico in Albuquerque. She is also a co-author of the AAMR.

- Because he can operate a fork lift."³²

When representing clients and considering whether they have mental retardation, it is important to guard against biases and misconceptions – in our opposing counsel and ourselves.

WHY SHOULD YOU CARE IF YOUR CLIENT IS A PERSON WITH MENTAL RETARDATION?

If you represent a client with mental retardation, you need to be aware that this could affect the case in a number of significant ways, including:

- **Your client's level of involvement in the crime itself.** Criminals often use persons with mental retardation to assist in illegal activities. People with mental retardation may not understand the significance or consequences of their actions.³³
- **Whether your client's statements are viewed as voluntary.** Though a person's statements are generally not excluded without evidence of impermissible coercive conduct, some advocates argue that the threshold for showing "coercive conduct" is lower if the defendant is mentally retarded.³⁴
- **Your client's ability to understand explanations of his/her rights, including Miranda warnings.**³⁵
- **Your client's ability to understand court proceedings.**
- **The reliability of your clients' statements.** Individuals with mental retardation often say what they think a police officer wants to hear.³⁶
- **The ability of your client to remember and recall events.**³⁷ Some people with mental retardation have limited ability to recall and remember events, particularly if they did not deem the event significant.
- **The ability of your client to knowingly, voluntarily, and intelligently waive rights,** including the right to counsel, right to be present, right to trial and appeal, and right to testify.³⁸ Persons with mental retardation often sign waivers that they cannot read or understand.
- **The ability of your client to meaningfully participate in trial preparation and at trial.**³⁹

These reasons signal the importance of being a vigilant advocate as you represent a client with mental retardation. Section 2 outlines the problems that defendants with mental retardation may face in the criminal justice system.

³² Robert Perske, *Unequal Justice? What Can Happen When Persons with Mental Retardation or Other Developmental Disabilities Encounter the Criminal Justice System* 41-42 (1991).

³³ Leigh Ann Davis, *People with Intellectual Disabilities in the Criminal Justice System: Victims and Suspects* (2005), at <http://www.thearc.org/NetCommunity/Document.Doc?&id=149> (last visited June 7, 2007).

³⁴ See Ellis & Luckasson, *supra* note 8, at 450-452.

³⁵ *Id.* at 449.

³⁶ The Arc of New Jersey, *supra* note 9, at 10.

³⁷ *Id.* at 5.

³⁸ Ellis & Luckasson, *supra* note 8, at 447-450.

³⁹ *Id.* at 452-54.



SECTION 2

WHAT PROBLEMS DO INDIVIDUALS WITH MENTAL RETARDATION FACE IN THE CRIMINAL JUSTICE SYSTEM?

Persons with mental retardation are over-represented in the criminal justice system. Although the prevalence of mental retardation within the general population is estimated at 2 to 3 percent,⁴⁰ studies indicate that individuals with mental retardation in the criminal justice system make up between 4 and 10 percent of the overall prison population.⁴¹ There are approximately 25,000 persons with mental retardation and other developmental disabilities in state and federal prisons.⁴² However, these estimates may be low. Approximately 15% of the inmates in Georgia's state prison system were on its mental health caseload at the end of fiscal year 2005.⁴³ The data for that year's annual report does not indicate the number of inmates who received services for being persons with mental retardation.⁴⁴ Some prison inmates with mental retardation may not have been identified at all. Research shows individuals with mental retardation make up an even higher percentage of the population in jails and juvenile facilities.⁴⁵

Most offenders with mental retardation are arrested for committing misdemeanors and public disturbances, as opposed to serious felonies.⁴⁶ Despite research suggesting that on average the crimes of defendants with mental retardation tend to be less serious than those of their non-disabled peers, their rates of conviction and incarceration are higher.⁴⁷ This is largely due to the unique challenges that defendants with mental retardation face in navigating the complexities of the criminal justice system.

Some characteristics that make individuals with mental retardation particularly vulnerable in the criminal justice system include the following:

- **Acquiescence.** When asked a "yes/no" question, persons with mental retardation are significantly more likely to answer "yes," regardless of the appropriateness of the response. This tendency is so strong that, according to one U.S. study of persons with mental retardation, 73 percent answered "yes" to the question, "Does it ever snow here in the summer?"⁴⁸
- **Concrete thinking.** Persons with mental retardation have difficulty thinking abstractly. One advocate gives the following example: "[T]he cliché 'That's the way the cookie crumbles' serves as an interesting abstract

⁴⁰ Joan Petersilia, *Doing Justice? The Criminal Justice System and Offenders with Developmental Disabilities 4*, available at http://www.seweb.uci.edu/users/joan/images/offenders_with_dd.pdf (May 2002; last accessed June 2007). *But see* Beirne-Smith et al., *supra* note 1, at 69 (There is, however, some disagreement about the prevalence of mental retardation in the general population – some place it at closer to 1%).

⁴¹ Petersilia, *supra* note 40, at 4. *See also* Davis, *supra* note 33; Morgan Cloud et al., *Words Without Meaning: The Constitution, Confessions, and Mentally Retarded Suspects*, 60 U. Chi. L. Rev. 495, 501 (2002).

⁴² Ray Gagnet et al., *Equal Justice for People with Mental Retardation, Individuals with Mental Retardation and the Criminal Justice System: A Training Guide for Allies 7* (2002).

⁴³ Georgia Department of Corrections, *Georgia Department of Corrections Annual Report Fiscal Year 2005 22* (2005).

⁴⁴ *Id.*

⁴⁵ Petersilia, *supra* note 40, at 4.

⁴⁶ Leign Ann Davis, *People with Mental Retardation in the Criminal Justice System* (2000) (citing *Opening the Door: Justice for Defendants with Mental Retardation* note 45, at 11 (1st ed., Texas Appleseed (2005)).

⁴⁷ Petersilia, *supra* note 40, at 4.

⁴⁸ Solomon M. Fulero & Caroline Everington, *Mental Retardation, Competency to Waive Miranda Rights, and False Confessions, in Interrogations, Confessions, and Entrapment 163, 169* (G. Daniel Lassiter ed., 2004).

response to a perplexing situation. Some of us with mental disabilities, however, may miss the larger meaning. We will look for the cookie.”⁴⁹

- **“Outer-directed” behavior.** Failures in academic and social settings may cause some individuals with mental retardation to rely more on social and linguistic cues provided by others when they are trying to answer questions. They may be more unsure of their answers, making them more easily influenced by an interviewer’s verbal and non-verbal cues.
- **Strong desire to please others.** Many persons with mental retardation want to provide a “socially desirable” response, so much so that they often will answer a question incorrectly just because they are telling the interviewer what they think the interviewer wants to hear.
- **Difficulty with “social intelligence.”** Persons with mental retardation cannot easily decipher the motives of other people and act on that information appropriately. As a result, they are more easily deceived than the general population. When they are asked why they confessed to a crime, many individuals with mental retardation respond, “They told me if I told them I did it, we could all go home.”
- **Highly “suggestible.”** Persons with mental retardation are much more likely to accept a suggested message as true than the general population. This makes them more likely to be influenced by leading questions and coercion in an interrogation setting.
- **Deference to authority figures.** Persons with mental retardation are accustomed to being wrong. So, if criminal justice professionals declare that the defendant has committed a crime, the defendant with mental retardation is apt to believe them. They may even tell authorities, “I don’t remember doing that, but if you say so. . . .”
- **Problems with receptive and expressive language.** Persons with mental retardation often have difficulty expressing themselves. They may also have difficulty understanding the ordinary flow of language. They may not understand complex sentences. You may need to speak to them more simply and clearly.
- **Limited memory and impaired recall.** Persons with mental retardation may have difficulty remembering and recalling events, particularly if they did not deem them to be important.
- **Impulsivity and short attention span.** Persons with mental retardation may have difficulty with attention span and focus.
- **“Cloak of Competence.”** The stigma of mental retardation is so great that individuals with mental retardation will often “mask” their disability in order to avoid its detection. This is true even when the consequences of having the disability identified would be beneficial to the person. Persons with mental retardation have often learned ways to avoid having their disability detected, and will go to great lengths to cover it up.⁵⁰

These characteristics may have an adverse effect at each level of the individual’s contact with the criminal justice system.

⁴⁹ Perske, *supra* note 32, at 16.

⁵⁰ Fulero & Everington, *supra* note 48, at 169-70; The Arc of New Jersey, *supra* note 9, at 4-5.

ARREST & DETENTION

Police Interrogation

Individuals with mental retardation may respond differently in interactions with police. This is due, in part, to the characteristics outlined above, but it is also often due to the limited amount of information they may have about the criminal justice system. Many of us gain this information in school; however, it is often overlooked in the standard special education curriculum.⁵¹ Much of the information that persons with mental retardation have about the justice system comes from popular television dramas.⁵² This puts individuals with mental retardation at a distinct disadvantage when they come into contact with the criminal justice system.

Persons with mental retardation may:

- **Not want their disability to be recognized because of the stigma associated with mental retardation.** This results in “masking” – trying to conceal their disability.⁵³ It may also lead them to overrate their own skills.⁵⁴ Law enforcement officers, who may lack the specialized training to identify mental retardation, may have difficulty recognizing a person who is attempting to mask a disability.⁵⁵
- **Have difficulty discerning when they are in an adversarial situation with police officers.** Often, they have been taught that police officers are people that they can trust and who have their best interests at heart. It may be difficult for them to distinguish the police officer’s role of helping people from their role of interrogating suspects.⁵⁶
- **Have a desire to please authority figures that can lead them to agree that they did something they did not do.** It is often difficult for individuals with mental retardation to consider a situation independently, or to think critically, when they encounter an authority figure.⁵⁷
- **Be overwhelmed by police presence, or agitated, frightened, or combative.**⁵⁸
- **Say what they think the police want to hear, even if it isn’t true.** Persons with mental retardation may defer to authority figures when faced with situations in which they are unsure.⁵⁹
- **Be confused about who is responsible for the crime and “confess” even if they are innocent.** Persons with mental retardation may have difficulty distinguishing between an incident that results from culpable behavior and one that results from events that are beyond their control.⁶⁰

⁵¹ Caroline Everington & Solomon M. Fulero, *Competence to Confess: Measuring Understanding and Suggestibility of Defendants with Mental Retardation*, 37 *Mental Retardation* 3, 212, 219 (1999); Petersilia, *supra* note 40, at 7. Hubert R. Wood and David L. White, *A Model for Habilitation and Prevention of Offenders with Mental Retardation*, in *The Criminal Justice System and Retardation* 153, 165 (Ronald W. Conley et al. eds., 1992).

⁵² Interview with Lilli Hallaam, former director of the Arc of Dallas Criminal Justice Initiative, August 9, 2005 (citing *Opening the Door: Justice for Adults with Mental Retardation*, note 51, at 13 (1st ed., Texas Appleseed 2005)).

⁵³ Burr et al., *supra* note 7, at 18.

⁵⁴ *Id.*

⁵⁵ Cloud et al., *supra* note 41, at 513-514.

⁵⁶ *Id.* at 512.

⁵⁷ Petersilia, *supra* note 40, at 24, 30; *see also* American Bar Association, *Criminal Justice Mental Health Standards* § 7-5.9 cmt (1989).

⁵⁸ The Arc of Dallas, *Capital Trial Advocacy and Mental Retardation – Atkins and Beyond*, materials from presentation by The Center for American and International Law (October 28, 2002).

⁵⁹ *Id.*

⁶⁰ Cloud et al., *supra* note 41, at 512.

- **Not understand their rights, including their right to be free from search and seizure and to refuse to consent.** Persons with mental retardation often answer affirmatively when they are asked if they understand their rights, even if they don't, in an effort to hide their disability or to gain approval. They may also fail to invoke their rights, even when they understand them.
- **Have difficulty with problem solving,** which may lead them to attempt to gain the friendship of authority figures whom they perceive to be good problem solvers.
- **Act upset at being detained or try to run away.**
- **Have difficulty describing the facts or details of the offense.**⁶¹

DID YOU KNOW...

A survey of persons with mental retardation found:

- 38% think they could be arrested for having a disability;
- 50% would disclose that they have a disability when arrested;
- 58% would talk to the police before talking to a lawyer, and
- 68% believe that the arresting officer would protect them.⁶²

Difficulty Understanding Miranda Warnings

Miranda warnings may be particularly difficult for individuals with mental retardation to grasp because they require an understanding of several abstract concepts. As mentioned above, persons with mental retardation tend to think in concrete terms. For example, some individuals with mental retardation may not understand what it means to waive a constitutional right. They may think instead that they are being asked to literally wave to the right, or wave their right hand.⁶³

Several studies have examined the difficulties that persons with mental retardation encounter with Miranda warnings.⁶⁴ These studies showed that the majority of individuals with mental retardation have great difficulty understanding the concepts conveyed in a Miranda warning, so much so that they would not be able to "knowingly and intelligently" waive their rights.⁶⁵

A study suggests that the number of people who have difficulty understanding Miranda warnings is larger than previously understood. It includes not only people with "severe" mental retardation, but also people whose mental retardation puts them at the upper end of functioning, previously classified under the old AAIDD definition as "mild."⁶⁶ The researchers note that no matter what other factors are present (using the "totality of the circumstances" factors -- IQ, age, educational level, experience with the criminal justice system, and history of being "Mirandized"), the "factor

⁶¹ Davis, *supra* note 33, at 2; Robert Perske, *The Police Interrogation of Persons with Mental Retardation and Other Cognitive Disabilities*, an abridgement from *Unequal Justice* (1991); Ellis & Luckasson, *supra* note 8, at 428-32.

⁶² Petersilia, *supra* note 40, at 24.

⁶³ Perske, *supra* note 32, at 17.

⁶⁴ Fulero & Everington, *supra* note 48, at 163-80; Everington & Fulero, *supra* note 51, at 212-220.

⁶⁵ Fulero & Everington, *supra* note 48, at 168.

⁶⁶ Cloud et al., *supra* note 41, at 501.

that matters" is whether a person has mental retardation.⁶⁷ They concluded, "If mental retardation is present, then the disabled person will not understand the warnings, regardless of the presence of other factors."⁶⁸

An alternate set of "simplified" Miranda warnings has been created for individuals with mental retardation. However, there is some disagreement as to whether these warnings are, in fact, more easily understood. One study suggests that persons with mental retardation may not understand the workings of the legal system sufficiently to understand the contextual meaning of even simplified warnings.⁶⁹

ALTERNATE MIRANDA WARNING

- **You have the right to remain silent.**
 - *"You do not have to talk to anyone. Tell me in your own words what I just said."*
- **Anything you say can and will be used against you in a court of law.**
 - *"If you talk, I can tell others what you said. Tell me in your own words what I just said."*
 - *"What you say can get you in trouble. Tell me in your own words what I just said."*
- **You have a right to talk to a lawyer and have him present at any time during questioning.**
 - *"You can talk to a lawyer. Tell me in your own words what I just said."*
 - *"Your lawyer can be with you if you talk to anyone. Tell me in your own words what I just said."*
- **If you cannot afford a lawyer, one will be appointed for you without cost.**
 - *"If you cannot pay for a lawyer, the judge will get one for you for free. Tell me in your own words what I just said."**

*From *Opening the Door: Justice for Defendants with Mental Retardation*, Appendix A (1st ed., Texas Appleseed (2005)).

Standardized assessments, including Instruments for Assessing Understanding and Appreciation of Miranda Rights, exist for determining whether a person understands Miranda warnings. This tool was originally designed for juveniles, but it has been used successfully with persons with mental retardation.⁷⁰

DID YOU KNOW...

Experts have determined that the Miranda warnings are written at a seventh grade reading level. While a small percentage of individuals at the upper end of functioning of mental retardation (IQ of 60-70) may be able to read at a sixth grade level, most will read at a significantly lower level. This means that even those who are at the upper level of functioning, formerly classified as "mild" mental retardation, will have difficulty understanding Miranda warnings.⁷¹

⁶⁷ *Id.* at 502.

⁶⁸ *Id.*

⁶⁹ *Id.* at 581.

⁷⁰ Celia S. Feinstein et al., *Equal Justice for People with Mental Retardation, Individuals with Mental Retardation and the Criminal Justice System: A Training Guide for Psychologists* 103 (2002).

⁷¹ *Id.* (noting that most individuals with mental retardation attain, at best, a fourth grade level of reading.) See also Fulero & Everington, *supra* note 48, at 174. (While we do not advocate using "mental age" to describe people with mental retardation, this illustrates the significance of the problem for people at the upper range of functioning of mental retardation who try to read or understand Miranda warnings).

Danger of False Confession

Each of the attributes of mental retardation leads to an increased danger of false confession.⁷² If someone has an enhanced desire to please authority figures, doesn't fully understand one's constitutional rights, is highly suggestible, acquiesces easily, is more easily influenced by verbal and nonverbal cues, and has a tendency to be more gullible or naïve than others, that person is clearly at increased risk of "confessing" to something that he or she didn't do. Certainly, even someone who exhibits only one of these characteristics is at higher risk for falsely confessing.

These characteristics are particularly problematic in the context of modern interrogation techniques, which may include an interrogator who:

- Establishes a position of authority, then endeavors to convince the suspect that the police are convinced of the suspect's guilt;
- Posits the suspect's guilt as fact;
- Cuts off a suspect's denial of guilt and dismisses and discourages exculpatory explanations;
- Emphasizes reasons why the suspect committed the act, rather than asks the suspect whether he or she did it; and
- Alternates shows of "kindness" with shows of hostility ("good cop, bad cop").⁷³

Thus, individuals with mental retardation experience inequity at two levels of the interrogation process: they are unable to understand (and therefore protect) their constitutional rights, as read to them in Miranda warnings; and commonly used police interrogation techniques play on their vulnerabilities.

This is made clear by numerous anecdotes of innocent people with mental retardation who were convicted of crimes after falsely confessing.⁷⁴

CASE STUDY - JOHNNY LEE WILSON

Johnny Lee Wilson was diagnosed with organic brain damage and determined to have mental retardation by the public school that he attended as a child. He was convicted of murdering the 79-year-old friend of his grandmother after "confessing" to the crime. After Wilson spent a decade in prison on a life sentence, evidence ultimately emerged supporting Wilson's innocence, and another man admitted guilt.

The transcript of his police interrogation illustrates the problems posed by employing the interrogation methods discussed above with a person with mental retardation. Although Wilson initially insisted he had been with his mother at the time of the murder, the police continued their interrogation. They told Wilson that if he confessed, "we can all go home." Wilson thought they meant he could also return home. The police told him that they were his friends and

⁷² American Bar Association, Criminal Justice Mental Health Standards § 7-5.8 (1989). (The American Bar Association's Criminal Justice Standards recognize that mental retardation affects both reliability and voluntariness of statements, even in the absence of coercion).

⁷³ Cloud et al., *supra* note 41, at 515.

⁷⁴ Human Rights Watch, *Defendants with Mental Retardation: Their Stories*, in *Beyond Reason: the Death Penalty and Offenders with Mental Retardation*, available at <http://www.hrw.org/reports/2001/ustat/> (March 2001, last visited July 2007); Perske, *supra* note 32.

wanted to help him:

Q: *And you know, this. . . isn't the end of the world for anybody. . . And so, you got a problem. And you need help. And we're the people that can get that done, John.*

A: *Uh huh.*

Q: *Rather than go through all this, John, rather than put you through the punishment, Steven and I, we want to help you tonight. We don't want you to be drug all through this. If there's something we can do tonight to help you, that's what we want to do.*

The police indicated that they had ample evidence of Wilson's guilt:

Q: *. . . You better start figuring out what's going to happen to John Wilson. That's what you better do.*

A: *Uh huh.*

Q: *. . . We've got the circumstantial evidence of you knowing about it before anybody else. We've got a case made. Doesn't it look to you like someone would be convinced that you did it based on what I just told you?*

A: *Yeah.*

Q: *It sure does.*

The police asked questions that suggested the answers. When Wilson told the officers that the victim's shirt was "white, kind of white or bluish blouse," the officer responded:

Q: *Okay, how about bluish? I'll go for that.*

A: *Yeah.*

Q: *How about bluish-green maybe?*

A: *Yeah.*

And in discussing the way the victim was bound:

Q: *What besides, what besides a rope was around her ankles? Something else. This is another test. I know. And you know. Just think. Come on, John.*

A: *I'm thinking.*

Q: *What are some things that could be used?*

A: *Handcuffs, I think.*

Q: *No. No. Wrong guess. What are some things you could tie somebody up with?*

A: *Rope is all that he had, but –*

Q: *That tells me something, John. That tells me something. That tells me something. I told you it's important that you be straight with me. You took the tape up there.*

A: *Huh?*

Q: *You took the tape up there, didn't you?⁷⁵*

⁷⁵ Perske, *supra* note 32, at 44-45.

Knowing more about some of the personality traits that are common to individuals with mental retardation makes it easy to see how this type of questioning results in false confessions.

PRE-TRIAL

Identification of Disability

Many advocates for persons with mental retardation suggest those who work within the criminal justice system often fail to recognize defendants with mental retardation. Law enforcement officers may not have training in recognizing mental retardation, and may mistake a person with mental retardation as someone who is drunk, on drugs, or who has a mental illness.⁷⁶ There is also some indication that counsel for defendants with mental retardation may not request pre-trial evaluations when they are needed.⁷⁷

When the system fails to identify defendants with mental retardation early in the process, there is a resulting failure to trigger the special procedures that exist to ensure that persons with mental retardation are diverted away from the criminal justice system. (See Section 6 for a discussion of pretrial options).⁷⁸

As a result, you may not be alerted to the possibility that your client is a person with mental retardation. It is therefore critical that attorneys learn to recognize possible signs of mental retardation, and follow up with appropriate evaluations. Recognizing these signs early will allow you to take the steps necessary to protect your client's constitutional rights, especially in cases in which your client has waived his or her rights and given a statement to the police.

DID YOU KNOW...

"Mental retardation is:

- Rarely identified at the time of the arrest.
- Rarely identified at the time of police questioning.
- Rarely identified at arraignment.
- Infrequently identified at trial.
- Occasionally (10%) identified at trial.
- Often not identified until the person is in prison or even on death row."⁷⁹

⁷⁶ Davis, *supra* note 46.

⁷⁷ The Arc of New Jersey, *supra* note 9 at 10; Joan Petersilia, *Justice for All? Offenders with Mental Retardation and the California Corrections System*, 77 *Prison J.* 358 (1997); Russell C. Petrella, *Defendants with Mental Retardation in the Forensic Services System*, in *The Criminal Justice System and Mental Retardation* 79, 85 (Ronald W. Conley et al. eds., 1992).

⁷⁸ Petersilia, *supra* note 40, at 10; John J. McGee and Frank J. Menolascino, *The Evaluation of Defendants with Mental Retardation in the Criminal Justice System*, in *The Criminal Justice System and Mental Retardation* 55, 63 (Ronald W. Conley et al. eds., 1992).

⁷⁹ William Edwards et al., *Equal Justice for People with Mental Retardation, Individuals with Mental Retardation and the Criminal Justice System: A Training Guide for Attorneys* 37 (2002).

Competence to Plead Guilty

Some research suggests that defendants with mental retardation are more likely to plead guilty, and often do so without the benefit of a plea bargain.⁸⁰ Two concerns are raised when defendants with mental retardation plead guilty, including:

- Reliability of admissions embedded within the plea; and
- Competence to plead guilty – a defendant with mental retardation may lack the capacity to make a sufficiently autonomous decision.⁸¹

As with a confession, the admissions contained within a guilty plea are suspect when the defendant has mental retardation. Just as there may be concerns regarding a client's competence to waive Miranda rights and to stand trial, there may be concerns about a client's competence to plead guilty. A defendant with mental retardation is at higher risk of waiving all of his or her rights in the adjudicative process by pleading guilty without fully understanding the implications of doing so.

TRIAL

Competence to Stand Trial

Attorneys frequently overlook competence to stand trial as an issue for clients with mental retardation.⁸² Yet, some defendants with mental retardation may have difficulty understanding the elements of the crime they have been charged with as well as basic trial procedures.⁸³ If you suspect that your client is not competent, you may be ethically bound to ask the court for an evaluation, even if your client does not want one. (See Section 7 for a discussion of the procedures relevant to a determination of competence.)

Juror Misconceptions of Mental Retardation

Many jurors have misconceptions about mental retardation. If your client does not exhibit any of the stereotypes that jurors expect to see in a person with mental retardation, they may believe a prosecutor's claim that your client is malingering.⁸⁴ You may want to ask prospective jurors questions about their understanding of mental retardation during voir dire.

The U.S. Supreme Court noted in *Atkins v. Virginia*⁸⁵ that defendants with mental retardation risk being unfairly judged during sentencing proceedings because their behavior may be misinterpreted as lack of remorse. Inappropriate behavior can also be a factor during the trial itself.

⁸⁰ Frank J. Laski, *Sentencing the Offender with Mental Retardation*, in *The Criminal Justice System and Mental Retardation* 137, 138 (Ronald W. Conley et al., eds., 1992); The Arc of New Jersey, *supra* note 9, at 10; Petersilia, *supra* note 77.

⁸¹ Ellis and Luckasson, *supra* note 8, at 460; Richard J. Bonnie, *The Competency of Defendants with Mental Retardation to Assist in Their Own Defense*, in *The Criminal Justice System and Mental Retardation* 97, 108 (Ronald W. Conley et al. eds., 1992).

⁸² Feinstein, *supra* note 70, at 95.

⁸³ Ellis and Luckasson, *supra* note 8 at 455-58.

⁸⁴ Denis W. Keyes et al., *Mitigating Mental Retardation in Capital Cases: Finding the "Invisible" Defendant*, 20 *Mental & Physical Disability L. Rep.* 529, 536 (1998).

⁸⁵ *Atkins v. Virginia*, 536 U.S. 304, 320-21 (2002).

Some defendants with mental retardation may exhibit behavioral characteristics that, if misunderstood, could influence a jury's decision. For example, many individuals with retardation smile a lot, sometimes inappropriately.⁸⁶ They may also laugh inappropriately. A jury may misinterpret these inappropriate responses as a lack of remorse.⁸⁷

A short attention span may spark behavior that a jury can misinterpret. For example, during the prosecutor's closing arguments at the defendant Johnny Paul Penry's retrial, Penry drew pictures on a piece of paper while the prosecutor listed reasons that Penry was vicious and deserved to die.⁸⁸

Defendants also may exhibit behavior that gives the impression that they do not have mental retardation. In an effort to "mask" disabilities, some defendants may take copious notes during trial in order to appear to be following and participating in the proceedings.⁸⁹

CONVICTION & SENTENCING

Research suggests that defendants with retardation are more readily convicted and receive longer terms than offenders without disabilities.⁹⁰ Probation and other diversionary programs are not used as frequently for offenders with mental retardation.⁹¹ Eligibility requirements for some diversionary programs may specifically exclude those who are physically or mentally disabled.⁹² Convictions are appealed less frequently, and post-conviction relief is not often requested.⁹³

PRISON

Persons with mental retardation generally do not fare well in a typical prison environment. Inmates with mental retardation are more likely to be victimized, exploited, and injured than non-disabled inmates.⁹⁴ They may have difficulty understanding jail and prison rules, and may spend more time in segregation as a result.⁹⁵ They may receive frequent disciplinary write-ups for failing to follow directions or pay attention.⁹⁶

Their difficulty understanding and following prison rules may also make them less likely to receive good-time or work-time credits and parole, and more likely to serve longer sentences.⁹⁷ When inmates with mental retardation are considered for parole, they often have a poor prison record with little program participation and many infractions and violations.⁹⁸ They may have difficulty during interviews with the parole board.⁹⁹

Georgia offers post-release programs to its criminal offenders, but some programs may not address the special needs of offenders with mental retardation. In addition, the prison system may not know that the offender is a person

⁸⁶ Perske, *supra* note 32, at 19; The Arc of New Jersey, *supra* note 9, at 5.

⁸⁷ Perske, *supra* note 32, at 19; Human Rights Watch, *supra* note 74, at 9.

⁸⁸ Perske, *supra* note 32, at 22.

⁸⁹ Burr et al., *supra* note 7, at 82.

⁹⁰ Petersilia, *supra* note 40, at 10; The Arc of New Jersey, *supra* note 9, at 10.

⁹¹ The Arc of New Jersey, *supra* note 9, at 10; Frank Laski, *supra* note 80, at 143.

⁹² Petersilia, *supra* note 77.

⁹³ *Id.*

⁹⁴ Ellis and Luckasson, *supra* note 8, at 480; McGee & Menolascino, *supra* note 78, at 69.

⁹⁵ Petersilia, *supra* note 40, at 4.

⁹⁶ Edwards, *supra* note 79, at 134.

⁹⁷ Petersilia, *supra* note 77.

⁹⁸ *Id.*

⁹⁹ *Id.*

with mental retardation. Without post-release programs, individuals with mental retardation are at higher risk for violating parole and for recidivism.¹⁰⁰ Thus, persons with mental retardation may cycle in and out of the criminal justice system.

DID YOU KNOW...

"[C]ompared to people who do not have mental retardation, the inmate with mental retardation does more time, does harder time, gets less out of his time, and is more likely to be returned once released from prison."¹⁰¹

¹⁰⁰ *Id.*

¹⁰¹ James G. Exum et al., *Points of View Perspectives on the Judicial, Mental Retardation, Services, Law Enforcement, and Corrections Systems*, in *The Criminal Justice System and Mental Retardation* 1, 12 (Ronald W. Conley et al. eds., 1992).



SECTION 3

THE INITIAL INTERVIEW

HOW CAN YOU TELL IF YOUR CLIENT HAS MENTAL RETARDATION?

As mentioned in Section 2, individuals with mental retardation tend to think in very concrete terms. They have difficulty understanding abstract issues. They may have difficulty with their receptive and expressive language skills. You may find that they have a short attention span.¹⁰²

Persons with mental retardation:

- May not communicate at age level and may have a limited vocabulary.
- May have difficulty understanding and answering questions.
- May mimic answers and responses.
- May not be able to communicate events clearly in their own words.
- May not be able to explain your questions in their own words.
- May be easily led or persuaded by others.
- May have a naïve eagerness to confess or please.
- May be unaware of social norms and appropriate behavior.
- May act younger than their actual age.
- May display low frustration tolerance and poor impulse control.
- May have difficulty staying focused and be easily distracted.
- May have awkward or poor motor coordination.
- May laugh or smile at inappropriate times.
- May have difficulty making eye contact.¹⁰³

They may also have difficulty reading and writing (apart from signing their name), telling time, obtaining a driver's license, recognizing coins and making change, and giving coherent directions.¹⁰⁴

Keep in mind that not all individuals with mental retardation will share these traits. Some may have difficulty in some areas, but strengths in others.¹⁰⁵ The reason that persons with mental retardation are not consistently identified in the criminal justice system is that they often do not exhibit any outward, readily identifiable signs that distinguish them as having a disability.

¹⁰² Perske, *supra* note 32, at 15-23.

¹⁰³ Handout on *Traits Often Seen in People with Developmental Disabilities*, The Arc of Dallas, pink laminated card given as part of their Criminal Justice Initiative.

¹⁰⁴ The Arc of New Jersey, *supra* note 9, at 8.

¹⁰⁵ Ellis & Luckasson, *supra* note 8, at 427.

WHAT DO YOU DO IF YOU SUSPECT YOUR CLIENT HAS MENTAL RETARDATION?

If you have any reason to believe that your client has mental retardation, you need to explore this possibility. Mental retardation can be a significant issue at a number of different phases of criminal cases. Having your client further evaluated may be critical to a fair outcome.

However, as previously mentioned, many individuals with mental retardation will go to great lengths to hide their disability from others.¹⁰⁶ This is primarily due to the stigma associated with mental retardation, but may also be due to an honest inability to accurately assess their own abilities.¹⁰⁷

If you suspect that your client has mental retardation, consider asking your client some of the following questions to help you determine whether you need to further explore this possibility.

- Were you ever in special education classes?
- Did you finish high school? If so, did you earn a certificate or diploma?
- Do you like to read? If so, what do you like to read?
- Have you ever worked? Where? What did you do when you worked? How long did you work? Did you have a job coach?
- Do you have a checking account at a bank? Does anyone help you take care of it? Does anyone help you pay your bills? Does your client have a representative payee?¹⁰⁸
- Do you drive? If not, how do you get around?
- Do you receive Supplemental Security Income (SSI)?
- Are there things, places, or people that make you afraid?¹⁰⁹

It is very important that you be tactful and respectful when you talk to your client about mental retardation. It may be a difficult or embarrassing process for them. Blunt questions like "Do you have mental retardation?" are unlikely to yield information. Such questions may also make your client uncomfortable and less likely to trust you. **Try to establish a good rapport with your client before you begin asking some of the delicate questions surrounding the client's disability. This will ensure that your client feels comfortable being open about this information.**

The following guidelines may be helpful for talking to clients with mental retardation.

- Be prepared for the interview process to require additional time and patience. You may need to repeat or rephrase questions once or twice.
- Try to arrange for a quiet and private setting, free from distractions.
- Identify yourself clearly to your client. Explain everyone's role and reason for being present at the interview.

¹⁰⁶ Burr et al., *supra* note 7, at 18.

¹⁰⁷ *Id.*

¹⁰⁸ A representative payee is someone who has been appointed by the Social Security Administration to receive your client's monetary benefits and to act as your client's fiduciary. You will want to interview your client's representative payee if one exists.

¹⁰⁹ The Arc of New Jersey, *supra* note 9, at 9; e-mail from Dr. James Patton (August 30, 2005) (citing *Opening the Door: Justice for Defendants with Mental Retardation*, note. 109, at 22 (1st ed., Texas Appleseed (2005)); Denise Quigley, Esq., The Georgia Advocacy Office; Jenny Manders, Ph.D., Institute on Human Development and Disability, University of Georgia (July, 2007).

- Use your usual tone and volume of voice.
- Make every effort to keep your language simple and clear.
- If possible, use visual aids.
- Avoid asking “yes or no” questions.
- Avoid legal jargon.
- Consider interviewing for short periods with frequent breaks, or conducting several short interviews instead of one long interview.
- Break complicated series of instructions or information into smaller parts.
- Avoid abstract questions about time sequences or reasons for behavior.
- Avoid rapid-fire questions.
- Treat adults with developmental disabilities in an age-appropriate manner.
- Occasionally check to make sure your client understands what you are saying – ask the client to repeat directions or questions in their own words.
- Offer help or support in a sensitive and respectful manner.
- Allow ample time for a response after you’ve asked a question. If you do not understand what your client has said, ask the client to repeat the answer.
- Speak to your client directly – do not talk through an accompanying parent or staff person. Avoid completing your client’s sentences, and do not attempt to speak for the client.
- Do not hesitate to ask your clients to explain to you what you have just told them.¹¹⁰

Avoid Big Words

Big words to avoid	Alternatives	Big words to avoid	Alternatives
weapon	Knife, gun, something that hurts someone else	charged	Accused, blamed
combative	Angry, fighting, mad, arguing	vehicle	Car, truck, something you ride in, something that carries you some place
peace officer	Police, sheriff, guard, patrol, deputy	suspect	The person who might have done the bad act
victim	A person who has been hurt by someone else	behavior	The way someone acts
assailant	A person who hurts someone else	accused	The person that people think has done a bad act
magistrate	Judge; the person in charge of the courtroom	perpetrator	The person who does a bad act

¹¹⁰ AAMR, *Guidelines for Interviewing People with Disabilities* (2005); Lilli Hallaam, Address delivered at The Center for American and International Law presentation, *Capital Trial Advocacy and Mental Retardation – Atkins and Beyond* (October 28, 2002).

probate	To let someone stay out of jail, to let someone have a shorter stay in jail	conceal	To hide something, to keep something a secret
bail	Money you pay to guarantee that you will come back to court	assault	To hurt somebody
deputy attorney	Police, guard, sheriff Lawyer	incarcerate confession	To go to jail, to be in jail To admit that you did something

USE A FACILITATOR

If you know that your client has mental retardation, you may want to consider having a “facilitator” or “interpreter” for the individual. Many advocates compare this to having an interpreter who uses sign language when speaking with a person who is deaf. The facilitator can be a volunteer, or someone that the defendant knows from the community. The facilitator should be someone that the defendant feels comfortable talking to, and who has experience communicating with persons with mental retardation. The facilitator should be able to foster communication between the defendant and others who converse with the defendant such that all parties are capable of understanding the meaning of what is being said.

If the defendant cannot suggest someone to help facilitate your conversations, you may want to call your local community mental health service provider or advocacy groups such as The Georgia Advocacy Office or The Atlanta Alliance on Developmental Disabilities and ask for their help in finding a volunteer facilitator. You may also want to contact your Regional office of the Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD). (For contact and resource information, see the list at the back of this handbook.)

You may need to ask the facilitator to attend the court proceedings to make sure that your client understands what is happening inside the courtroom. If your client is going to testify, you will want to have a “cognitive interpreter,” someone who operates like a facilitator, but who is a mental retardation expert trained to help witnesses with mental retardation understand questions and communicate answers.¹¹¹ The presence of a facilitator or cognitive interpreter in the courtroom also serves as a continual reminder to the jury that your client is a person with a disability. This reminder may make it more difficult for jurors to disregard your client’s disability as they consider the case. You should weigh the pros and cons of using a facilitator before the trial, perhaps by talking to other attorneys who have done so.

PREPARE YOUR CLIENT FOR COURT APPEARANCES

You may need to prepare your client for court appearances by discussing appropriate behavior and dress. Behavior that is inappropriate can affect the judge’s or jury’s view of your client. Visiting a courtroom and orienting your client to the room and court procedures will help to ease the client’s anxiety and may reduce the likelihood of inappropriate behavior.

¹¹¹ Hallaam, *supra* note 110.



SECTION 4

HELPFUL HINTS FOR OBTAINING INFORMATION

If you suspect that your client may have mental retardation, you may want to look for records that will help you explore the issue further.

WHERE SHOULD YOU LOOK FOR MORE INFORMATION REGARDING MENTAL RETARDATION?

- Talk to your client's family.
- Talk informally with jail staff.
- Find out whether your client was evaluated during intake.
- Look at the police report for any indication of behavior that may suggest mental retardation.
- If an evaluation has been conducted pursuant to the Georgia criminal code, you should obtain a copy of the mental health expert's report.¹¹² You should also know that the prosecutor and judge will receive a copy of this report. This type of assessment is often used to divert individuals with mental illness from jail into treatment. If your client has been evaluated, and the assessment indicates your client may have mental retardation, you may want to use this evaluation to support an argument for diversion.
- If your client is being charged with a probation violation, ask your client's probation officer about any special conditions of your client's probation. If he or she was identified as an offender with mental retardation at an earlier point, your client may be involved in a special treatment, habilitation, or diversion program.
- If your client has been in court before, look to see if competence proceedings were conducted.
- Look at information about your client collected by the pretrial release program.
- If your client was interviewed or confessed to a crime, try to obtain a copy of the taped interview if one exists.

WHAT RECORDS MIGHT BE HELPFUL?

- **Medical and mental health records of the client.** Medical records may reveal that your client failed to meet normal milestones in development. They could also reveal etiological factors that may have resulted in or contributed to your client's developing mental retardation. Some of these factors include the following:
 - Heredity. Includes genetic and chromosomal aberrations (Down syndrome, fragile X syndrome, Tay-Sachs disease, tuberous sclerosis, and other disorders that may be inherited).
 - Alterations of embryonic development. May include chromosomal changes or prenatal damage due to toxins (maternal drug and alcohol consumption, in-utero infections, prescription medications, and other embryotoxins).
 - Pregnancy and perinatal problems. May include fetal malnutrition, fetal alcohol syndrome, prematurity, hypoxia, trauma, and viral and other infections.
 - General medical conditions acquired in infancy and childhood. May include infections, traumas, and poisoning (such as exposure to lead).
 - Environmental influences and other mental disorders. May include lack of nurturing; deprivation of social, linguistic, and other needed stimulation; and severe mental disorders (such as Autistic Disorder).¹¹³

¹¹² Ga. Code Ann. §§ 17-16-4 (2005), 37-4-125 (2002), 37-3-166 (1994).

¹¹³ Robert A. Hager & Victor R. Scarano, *Making Sense of the Records*, in *Mental Capacity – Special Legal Issues Relating to Mental Retardation 1* (Texas Bar CLE ed., 2003).

- **Medical records of client family members.** Your client's family members' medical records could show a familial history of developmental disabilities. These records could also reveal problems that your client's mother experienced during pregnancy, as well as any history of substance or alcohol abuse during the pregnancy.

Privacy of medical records: It is important to note that federal law governs the privacy of medical records under the Health Insurance Portability and Accountability Act of 1996 as implemented in Title 45 of the Code of Federal Regulations. Medical records may be released to third parties other than the patient when the patient consents to such a release or when a court grants a subpoena ordering such a release. If the family members of your client consent to the release of their medical records, it will be important for you to ascertain whether those medical records will be discoverable. Some family members may not want the contents of their medical records to be disclosed to persons other than you and your staff.

- **School records.** Your client may have been enrolled in special education classes. You may also be able to determine whether your client had persistent failing grades, more than one non-promotion, or persistent below grade-level achievement scores. School records may also include the results of psychological evaluations, if any were done. Keep in mind that schools have become increasingly wary of labeling a student as having mental retardation because of the stigma that is attached to the definition, or because of the additional cost of providing special services. Even if the records only reflect that your client is "learning disabled," there may be significant evidence that he or she tested within a range that makes your client eligible for a diagnosis of mental retardation. Individuals who are familiar with academic transcripts and test records should also evaluate these records, since such records tend to include unfamiliar acronyms.
- **Vocational evaluation records.**
- **Social service agency records.** If your client has received services from community mental health centers or other social service agencies, their records may contain useful information.
- **Social Security records.** These may show that a client has been diagnosed with mental retardation and was provided with disability payments.
- **Military records.** If your client served in the military, limitations in adaptive functioning may have resulted in a discharge, lack of advancement, or frequent disciplinary charges.
- **Employment records.** These may reveal whether your client had difficulty holding a job, or experienced disciplinary problems at work that are consistent with mental retardation. They may also reveal that your client was not able to fill out an employment application – check the handwriting on the application to see if your client had help.
- **Juvenile and criminal records.** Many clients with mental retardation will have had numerous prior arrests or commitments within the juvenile system for relatively minor offenses.
- **Prison records.** If your client has been incarcerated in the past, there may be a record of IQ scores on intake tests (See Section 11 for more information on types of testing.) Prison records may also document difficulties following prison rules and suggest other limitations in adaptive behavior.
- **A client's history and record of substance abuse as a child.** A history of glue or paint huffing, psychedelic substance, PCP, and other drug use provides important information, particularly if the child was hospitalized after intentionally or unintentionally overdosing on these substances.

- **A family diary or record of your client’s developmental milestones.** Some mothers keep a baby book or journal to record various milestones. These documents can be helpful in determining age of onset of your client’s disability.¹¹⁴

Because many local agencies and departments may not be thoroughly familiar with all aspects of Georgia law, ask your client to sign a records release form at the time of your first interview if your client is able to do so. Even better, call the institution from which you are seeking records and request a copy of its records release form. If your client cannot sign a medical records release form, you may be able to obtain the needed records by forwarding the institution a certified copy of the order appointing you to the case. If none of these methods works, you may be able to get the records by seeking a subpoena or court order.¹¹⁵

YOU MAY ALSO CONSIDER TALKING TO:

- Knowledgeable extended family members
- Child care workers
- Teachers
- Social service providers
- Previous health care providers
- Religious leaders and religious education teachers
- Friends
- Co-workers
- Co-defendants in criminal offenses

You should seriously consider hiring a mitigation specialist who can gather the information discussed in this section for you. Once you have this information, see where it takes you. Retaining a mitigation specialist is also relevant to effective assistance of counsel issues. (See Section 9 for more information on mitigation specialists.)

¹¹⁴ See Burr et al., *supra* note 7, at 19-23; Victor R. Scarano & Bryan A. Liang, *Mental Retardation and Criminal Justice: Atkins, the Mentally Retarded, and Psychiatric Methods for the Criminal Defense Attorney*, 4 Hous. J. Health L. & Pol’y 285, 304-05 (2004).

¹¹⁵ Ga. Code Ann. §§ 31-33-2 (1985), 24-9-40 (1993).



SECTION 5 DUAL DIAGNOSIS

Dual diagnosis refers to a combined diagnosis of mental retardation and either alcohol abuse, substance abuse, or mental illness.¹¹⁶ Types of mental health disorders are the same in individuals with and without mental retardation.¹¹⁷ However, persons with mental retardation are at increased risk for a mental illness.¹¹⁸ The prevalence of common mental health disorders in individuals with mental retardation is:

- Anxiety disorder up to 35 percent
- Post-traumatic stress disorder 22 percent
- Psychosis 2-5 percent
- Depression up to 30 percent
- Personality disorder 3 percent
- Substance abuse up to 20 percent¹¹⁹

The prevalence of anxiety and stress disorders is greater among persons with mental retardation compared with the general population of the same age.¹²⁰

Identifying mental illness in persons with mental retardation can be difficult.¹²¹ Most diagnostic procedures rely heavily on a person's ability to report his or her symptoms.¹²² If a person with mental retardation has difficulty communicating, reporting symptoms of mental illness may also be difficult.¹²³ Conventional assessment instruments are not designed for use with this population, and while specialized instruments have been developed, there is some disagreement as to whether they are very useful.¹²⁴ Often, the mental illness masks the mental retardation. Once the mental illness is treated (often through medication), the mental retardation may become evident.

The National Association for the Dually Diagnosed (NADD) is a good resource for information about dual diagnosis. Their website is www.thenadd.org.

HOW CAN I TELL IF MY CLIENT HAS A MENTAL ILLNESS?

While it may be difficult to determine whether a client with mental retardation also has a mental illness, interviews with family and friends may be helpful in discerning your client's mental health history. Your review of the records and police reports, as discussed in Section 4, may also reveal treatment for or symptoms of a mental illness. The Georgia Public Defender Standards Council, Office of the Mental Health Advocate, maintains an extensive list of medications

¹¹⁶ John H. Noble, Jr. & Ronald W. Conley, *Toward an Epidemiology of Relevant Attributes*, in *The Criminal Justice System and Mental Retardation* 17, 26 (Ronald W. Conley et al. eds., 1992)
¹¹⁷ AAMR, *supra* note 10, at 172-74.
¹¹⁸ Beirne-Smith et al., *supra* note 1, at 200.
¹¹⁹ AAMR *supra* note 10, at 174.
¹²⁰ *Id.* at 172.
¹²¹ Beirne-Smith et al., *supra* note 1, at 200; McGee & Menolascino, *supra* note 78, at 67.
¹²² *Id.*
¹²³ *Id.*
¹²⁴ *Id.*

that are used for treating persons with mental illness. This list can be accessed on the internet at http://www.gpdsc.org/omha-resources-psych_meds_101.htm. For definitions of common mental health terms, see the Glossary of Common Mental Health Terms at the end of this handbook.

It is important to know that there may be some overlap between the signs or symptoms of mental illness and the signs of mental retardation. However, during your time with your client, you may want to look for:

- **Certain types of offenses.** Offenses such as criminal mischief, criminal trespass, failure to identify, and public intoxication may signal an underlying mental illness or substance abuse problem. Many defendants with mental illness are also brought in on charges of "assault of a public servant" because they tangle with police while they are psychotic. These offenses are frequently related to the client's poverty, homelessness, substance abuse, or transient lifestyle, but if they are part of your client's offense history or if your client has been arrested several times for the same offense, the client may have a mental illness.
- **Behavioral or physiological clues.** Your client may exhibit rapid eye blinking, vacant stares, tics or tremors, or unusual facial expressions. The symptoms of a mental illness and the medications your client may be taking may make the client appear slow, inattentive, or sluggish. Your client may exhibit psychomotor retardation (slow reactions in movements or answering questions) or clumsiness. Your client may be excessively uncooperative. On the other hand, your client may appear very agitated, tense, or hypervigilant. Many of the common behavioral clues for mental illness may be similar to behavior that is typical of persons with mental retardation. Do not assume that your client has a mental illness based purely on these behavioral clues if you know your client to be a person with mental retardation.
- **Circular nature of your client's conversation.** You may note that your client doesn't follow a logical train of thought when you are talking with each other. In other words, your client may be unable to get from point A to point B. Again, while this may be symptomatic of mental illness, your client may simply have difficulty with communication. It may also reflect your client's desire not to talk about the disability or unfamiliar subjects.
- **Use of mental health terms.** If your client has been treated for mental illness, he or she may talk about a counselor or caseworker, about various medications, or about being treated in a hospital. Your client may use terms commonly used in the mental health care field.
- **Paranoid statements.** Your client may make paranoid statements or accusations. Or, your client may exhibit phobias or irrational fears, such as a fear of leaving the jail cell.
- **Reality confusion.** Your client may experience hallucinations, hear voices, see things, have illusions, or misperceive a harmless image as threatening. Your client may be disoriented and seem confused about people and surroundings. Your client may have delusions (consistent false beliefs), such as that lawyers are out to get him or her, that guards are in love with him or her, or that his or her food has been poisoned.
- **Speech or language problems.** Your client may exhibit language difficulties, including incoherence, nonsensical speech, the use of made-up language, and non sequiturs. Your client may change the subject in mid-sentence, speak tangentially, or speak repetitive language. Alternatively, the client may exhibit rapid, racing speech, or give monosyllabic or lengthy, empty answers. Your client may be easily distracted or may substitute inappropriate words for other words. Again, a trait typical of persons with mental retardation is difficulty communicating.
- **Inappropriate emotional tone.** Your client may exhibit emotions such as anxiety, suspicion, hostility, irritability, or excitement; or may appear downcast and depressed. On the other hand, your client may express little emotion at all or appear to have a flat affect. Your client may exhibit emotional instability. Clients diagnosed with bipolar disorder (manic depression) may talk in a very rapid manner, seem excited,

laugh at inappropriate times, make grandiose statements, or act very irritated. As noted earlier in this handbook, this could also be true of individuals with mental retardation who do not have a mental illness.

- **Unusual social interactions.** Your client may have problems relating to others, and experience isolation, estrangement, difficulty perceiving social cues, emotional withdrawal, a lack of inhibition, or strained relations with family members and friends.
- **Medical symptoms and complaints.** Finally, you should always be alert for physical symptoms, including hypochondria, self-mutilation, being accident-prone, insomnia, hypersomnia, blurred vision, hearing problems, headaches, dizziness, nausea, and loss of control of bodily functions. Some of these problems can develop as a result of incarceration, but many point to other, more serious or long-standing mental health problems.
- **Thoughts of death or suicide.** You may learn that your client is suicidal during discussion with the client or client family members.

WHEN TALKING WITH FAMILY AND FRIENDS, YOU MIGHT ASK:

- Do you know if the client has ever been treated for a mental or emotional problem?
- Has the client ever been treated for substance abuse?
- Is the client currently receiving treatment? If so, with whom?
- Do you know the client's diagnosis?
- Do you know what types of medication the client is taking? Has the client taken medications in the past? What were those medications?
- Has the client ever been hospitalized for a mental health problem? If so, when and where? Did a court or judge order the hospitalization?

You should conduct further inquiry if you have any concerns about your client's mental health. Because many symptoms and behaviors of persons with mental retardation may overlap with those of individuals with a mental illness, you should consult a mental health expert if you have any concerns regarding your client's mental health.

In talking to a client with a mental illness you may find that the illness exacerbates the communication difficulties that persons with mental retardation may face. As with mental retardation, many persons with mental illness will go to great lengths to hide their illness. Some clients may not understand that they are mentally ill. If your client seems to be aware that he or she has a mental illness, you may try asking your client simplified questions similar to the ones listed above.

Use eye contact to keep control of the dialogue and keep your client focused. Do not intrude on your client's "personal space." Tell your client when you do not understand and need more information. Paraphrase your client's responses to let him or her know that you understand. Remember, your client's delusions are real to him or her. Do not minimize or try to explain away hallucinations or delusions. You will likely elicit more information with a response such as, "That's interesting – tell me more," than by arguing the logic of statements that may appear bizarre or unusual to you.

Be patient. A client with mental illness may be irritated, belligerent, or see you as a threat. A client who is out of control may have a mental disorder. Some of your client's actions, reactions, and mannerisms may be irritating or

offensive. Do not take this conduct personally; mental illness may influence your client's personality. Find out if your client has stopped taking medication. Your interactions with your client are likely to improve if you can get the client to start taking medication again.

As with mental retardation, do not speak about mental illness in a disparaging or derogatory manner. Do not add to your client's feelings of helplessness, embarrassment, or shame about having mental illness. If you believe your client is incompetent, you should still address your client as if he or she is competent. Many clients who get better after treatment remember how you treated them and what you said to them before treatment. You are more likely to create a good relationship with your client and to offer better representation if the client feels treated with respect.

You may consider videotaping an early interview with a client who is exhibiting psychotic behavior. This will allow the judge or jury to see how the client was behaving near the time of the offense. Such evidence may be critical for proving an insanity defense.

WHERE DO I SEEK GUIDANCE IF MY CLIENT MAY BE MENTALLY ILL?

The Georgia Public Defender Standards Council, Office of the Mental Health Advocate, is a division of the executive branch of the state government.¹²⁵ The Office of the Mental Health Advocate offers guidance to attorneys throughout Georgia who represent clients with mental illness. It also works closely with mental health courts that have been established throughout the state. Some of the services its offices can provide include lists of psychologists and psychiatrists who perform mental health evaluations, information on community placements for residential and day treatment programs, and sample motions, orders and other pleadings. The Office of the Mental Health Advocate can be contacted by calling (404) 232-8900, or by visiting <http://www.gpdsc.org/omha-main.htm> on the internet.

Your Regional MHDDAD can also provide information and guidance about working with clients with mental illness. Contact numbers for Regional MHDDAD offices are located in the back of this handbook.

¹²⁵ Ga. Code Ann. § 17-12-1 (amendment effective July 1, 2007)



SECTION 6

PRETRIAL OPTIONS

TRY TO GET THE CASE DISMISSED

You should explore ways to get your client's case dismissed. What may seem like a minor misdemeanor conviction could come back to haunt your client down the road. You can attempt to get a dismissal in various ways. However, if you have never represented a person with mental retardation before, get help from someone who has before you proceed.

The Americans with Disabilities Act (ADA) prevents discrimination against people with disabilities who are not a direct threat to public health or safety.¹²⁶ The Americans with Disabilities Act may protect a client with mental retardation or mental illness. Be mindful of unfair or discriminatory treatment of your client by anyone in the criminal justice system, including jailors or prosecutors. More information about accommodations that should be provided to your client under the ADA can be obtained from The Arc website at www.thearc.org, your Regional MHDDAD office, or from other organizations listed at the back of this handbook.

TALK WITH THE PROSECUTOR

If you have any indication that your client's mental retardation may have played a role in the charged offense, consider talking to the prosecutor about dismissing your client's case. You should also discuss the facts of the offense closely with your client to determine his or her level of involvement in the crime. Other people often use persons with mental retardation to commit crimes. They tend to be the last to leave the scene of the crime, and the first to get caught. If your client is used by others to commit a crime, and did not understand the consequences, this may help you to get the case against your client dismissed.

The prosecutor may be more inclined to share your conviction that your client has mental retardation and that this could have affected your client's judgment if you clearly document your client's disability and then provide the documentation to the prosecutor. However, if you are new to practice or otherwise unfamiliar with the prosecutor, you should talk to other attorneys in the community about the prosecutor's sensitivity to mental retardation issues. If you have concerns, you may want to seek out another prosecutor or speak to the prosecutor's supervisor.

Approaching a prosecutor with evidence of your client's mental retardation - before you have completed the investigation needed to conclusively prove a diagnosis - poses a risk that the prosecutor will be given early discovery and will insist on having one of the state's experts test your client.¹²⁷ To determine whether this option is worth pursuing, you should consider the following questions.

- Does the evidence meet all three diagnostic criteria (see Sections 1 and 11)?
- Are the historic full scale IQ scores consistently lower (taking the appropriate SEM into account)?
- Is at least one of the historic IQ scores that are 70 or lower derived from a reputable, reliable test that was properly administered?

¹²⁶ 42 U.S.C. § 12101.

¹²⁷ Burr et al., *supra* note 7, at 25.

- If the historic IQ scores include full scale IQ scores above 70, is there a reasonable basis for believing that the score overstates the client's true intelligence?
- Is there evidence that the onset of limitations in intellectual functioning and adaptive behavior occurred during the client's developmental period, i.e., before the age of 18?
- Are there any major downsides to the administration of a reputable, reliable IQ test by a prosecution expert?
- Could the SEM, the "practice effect," and the "Flynn effect" have had an impact on your client's IQ test scores? (See Section 11 for a discussion of each of these.)¹²⁸

TALK WITH THE COMPLAINING WITNESS

The option of an outright dismissal may be more appealing to the prosecutor in a case where there is no alleged victim. If there is an alleged victim and the prosecutor does not want to dismiss your client's case, you may consider contacting the alleged victim directly and, with your client's permission, presenting evidence of your client's mental retardation. The alleged victim may then go to the prosecutor and ask the prosecutor to drop the charges against your client. This approach can backfire, however. You may end up aggravating the alleged victim. Be sure to discuss the pros and cons of this option carefully with your client before you proceed.

TALK WITH THE ARRESTING OFFICER

Finally, you may want to determine whether the arresting officer would be willing to ask the prosecutor to dismiss the charges, especially if your client is charged with a nonviolent offense or the arresting officer is the complainant. You may be able to get the officer to work with you if you offer evidence of your client's mental retardation.

RELEASE ON CONDITIONAL BOND

If a quick dismissal is not an option and your client is competent to stand trial, you should speak to your client about whether to seek his or her release on bond. Georgia law provides for the release of defendants on conditional bond if they are being evaluated for mental competence to stand trial and the court determines that the defendant meets the criteria for release on bond or other pre-trial release pursuant to the Official Code of Georgia Annotated.¹²⁹ The court may allow the Department of Human Resources to evaluate your client on an outpatient basis. If the court allows outpatient evaluation and your client is in custody and charged with committing a nonviolent misdemeanor or nonviolent felony, the court may release the client in accordance with the provisions of the criminal procedure sections of the Georgia code.¹³⁰ Remember, if your client, the defendant, requests the psychiatric evaluation, then the written report from the evaluation will be submitted to you. If the prosecutor or the judge requests the evaluation, then the results will also be submitted to the prosecuting attorney and the court. The report might be used against your client later. You and your client may also decide not to pursue a release on bond if your client is homeless or does not have a safe or stable place to live. If your client is in danger of picking up additional charges while on bond or failing to report to court as required by the provisions of the bond, release may significantly impair your chances of getting your client's case dismissed. If you are further along in the pretrial process and your client has been determined to be incompetent, but is not considered a danger to others, Georgia law provides that your client can be

¹²⁸ *Id.*

¹²⁹ Ga. Code Ann. § 17-6-1 (2006).

¹³⁰ *Id.*; See also Ga. Code Ann. § 17-7-130(b) (2007).

released on conditional bond if the court determines that he or she can adequately be treated on an outpatient basis.¹³¹

COMPETENCE ISSUES

As discussed in Section 2, many individuals with mental retardation have difficulty understanding Miranda warnings. They may also confess to crimes they did not commit. You should explore these issues fully to determine whether an appropriate pre-trial motion should be considered.

If you are considering a guilty plea, you should have your client evaluated to determine whether he or she is competent to enter a plea.

For a full discussion of competence to stand trial, see Section 7.

DEATH PENALTY ELIGIBLE DEFENDANTS

If your client is eligible for the death penalty, you should file a pretrial motion to establish his or her mental retardation. Death penalty cases are beyond the scope of this handbook. Nevertheless, limited details about mental retardation and the death penalty are offered in Section 10.

¹³¹ Ga. Code Ann. §§17-6-1, 17-7-130.



SECTION 7

COMPETENCE EVALUATIONS AND TRIALS

THE BASICS

First, you should be aware that most Georgia criminal statutes that apply to persons with mental illness also apply to persons with mental retardation. Therefore, if your client has mental retardation, you should consider whether he or she is competent to stand trial.

A special plea of incompetence is not a determination on the merits of your client's case. In other words, a special plea of incompetence will not resolve the offense against your client. In Georgia, your client will be deemed competent to stand trial if the client (1) can understand the nature and object of the proceedings, (2) can comprehend his or her own condition in reference to the proceedings, and (3) is capable of rendering to you assistance in providing a proper defense.¹³²

Your client's competence involves more than the ability to correctly identify the different actors in the court process (for example, the prosecutor, judge, defense attorney, or bailiff). You may want to consider asking yourself the following questions to help determine whether it is appropriate to request a competence examination for your client.

- Does your client understand his or her legal situation?
- Does your client understand the charges against him or her?
- Does your client understand the legal issues and procedures in the case?
- Does your client understand the available legal defenses?
- Does your client understand the depositions, pleas, and possible penalties?
- Can your client appraise the likely outcomes of the case?
- Can your client appraise his or her role and the roles of defense counsel, prosecutor, judge, jury, and witnesses in the case?
- Can your client identify and locate witnesses?
- Does your client trust you and communicate relevant information to you, including pertinent facts, events, and states of mind?
- Does your client comprehend instructions and advice?
- Can your client make decisions after receiving advice?
- Is your client able to collaborate with you on developing legal strategy?
- Can your client follow his or her own testimony and the testimony of others for contradictions or errors?
- Can your client testify about relevant information and be cross-examined if necessary?
- Can your client help you challenge prosecution witnesses?
- Can your client tolerate the stress of the trial process?

¹³² *Florescu v. State*, 276 Ga.App. 264 (2005), citing *Drope v. Missouri*, 420 U.S. 162, 171 (II) (1975); see also Ga. R. Unif. Super. Ct. r. 31.4.

- Can your client refrain from inappropriate behavior in court?
- Can your client disclose pertinent facts about the alleged offense?

A defendant is presumed competent to stand trial unless proven incompetent to stand trial by a preponderance of the evidence.¹³³

COMPETENCE EVALUATIONS

When is it appropriate to file a special plea of mental incompetence?

Generally, issues relating to your client's competence to stand trial should be resolved before the trial on the merits. However, you can request a competence examination at any point during the proceedings at which you believe your client is not competent to stand trial – even if you are in the middle of trying your client's case on the merits. You should note that the American Bar Association (ABA) has resolved that it is improper to use competence procedures for unrelated purposes, such as obtaining mitigation information, obtaining favorable plea negotiations, or delaying proceedings.¹³⁴

Many attorneys find themselves in an ethical bind when their client objects to having the competence issue raised. Some clients facing misdemeanor charges just want to plead to the charges, spend a short time in jail, and then get out. Often, having an evaluation means that the client will spend more time in jail pending the examination, plus a lengthy time at the state Regional hospital if he or she is found incompetent. Georgia law limits the number of days the Department of Human Resources has to conduct a preliminary evaluation of the competence of your client.¹³⁵ Based on the recommendation of the preliminary evaluation, your client is subject to undergoing further treatment, civil commitment, or release, pending the outcomes of further court hearings. Be aware, however, that a defendant charged with committing a misdemeanor cannot be civilly committed for a period exceeding 12 months. After this time, charges against your client must be dismissed by operation of law.¹³⁶ The ABA stresses a lawyer's professional responsibility toward the court and the fair administration of justice as the paramount obligations in such cases, and expects an attorney to advance the issue, even over a client's objection, whenever a good faith doubt arises about a defendant's competence to stand trial.¹³⁷ Of course, the client who is competent to stand trial makes the final decision about how to dispose of the case regardless of whether you agree with that decision or not.

If you believe your client is incompetent to stand trial, you should file a special plea of mental incompetence under the criminal procedure provisions of the Georgia code.¹³⁸ You should also seek to get your client's case dismissed. If the case is not dismissed, competence evaluations and trials can be conducted even if your client is on bond or otherwise out of jail.

¹³³ *Sims v. State*, 279 Ga. 389 (2005).

¹³⁴ American Bar Association, Standards Relating to Competence to Stand Trial § 7-4.2(e) (1989).

¹³⁵ Ga. Code Ann. § 17-7-130 (2007).

¹³⁶ *Id.* at § 17-7-130(d)(B)(i).

¹³⁷ American Bar Association, *supra* note 134, at § 7-4.29(c).

¹³⁸ *Supra* note 135.

Requesting the Competence Examination

If you believe that your client is not competent to stand trial, file a motion suggesting that the defendant may be incompetent, pursuant to the provisions of the Georgia code, regardless of whether your client is in jail or out on bond.¹³⁹ Even though defense counsel usually files such a motion, the court itself or the prosecutor may raise the issue of incompetence to stand trial. Once the issue is raised, the court proceedings must cease until the question of competence has been resolved. If you, the prosecutor, and the judge agree that your client may be incompetent, your client will be transferred to the Department of Human Resources for inpatient evaluation, and if necessary, treatment. If your client is charged with a nonviolent offense, the evaluation may be done on an outpatient basis. If there is disagreement about the matter of your client's incompetence, the court will either conduct a bench trial or convene a special jury to determine your client's competence to stand trial.¹⁴⁰ During the competence trial, your client carries the burden of proof on the issue of competence. If the judge or the special jury finds that your client is not competent, the court will order the Department of Human Resources to evaluate your client on an inpatient or outpatient basis.¹⁴¹ As a practical matter, the judge is more likely to conduct a bench trial rather than convene a special jury if there is disagreement about the matter of your client's competence.

Evaluating Experts

The defendant, the court, or the district attorney may choose an expert to evaluate the defendant when a special plea of incompetence is filed. The expert must be a medical doctor or licensed psychologist who holds a doctorate degree.¹⁴² The defendant can also be examined by an expert of his or her own choice. In addition, the state must pay for or reimburse an indigent defendant for an independent mental health expert if the defendant's mental status at the time of the charged crime will be at issue in the trial.¹⁴³

When you are representing a client with mental retardation, it is imperative that you make the court aware of the need for an evaluator who has experience in determining competence in clients with mental retardation. Mental retardation experts and mental health experts rarely overlap.¹⁴⁴ While many psychiatrists study mental retardation during their training, they may not have relevant experience in diagnosing or providing services for individuals with mental retardation.¹⁴⁵ Many psychologists also lack this experience. They should not be considered mental retardation experts if they do not have experience working with persons with mental retardation.¹⁴⁶

There is a standardized instrument specifically designed for assessing the competence of defendants with mental retardation, the Competence Assessment to Stand Trial for Defendants with Mental Retardation (CAST*MR). This test is widely used.¹⁴⁷ To determine whether an evaluator is experienced in assessing individuals with mental retardation, you should consider asking whether the expert is familiar with, or has ever used, this instrument. However, it is not appropriate to make a competence recommendation based solely on the score of this test. Your expert should also spend some time interviewing your client.¹⁴⁸

¹³⁹ *Id.*

¹⁴⁰ Despite the language of Ga. Code Ann. § 17-7-130(b), judges rarely empanel a special jury to hear the matter of a defendant's competence if the parties cannot stipulate to the defendant's competence to stand trial.

¹⁴¹ Ga. Code Ann. § 17-7-130(b).

¹⁴² *Id.* at § 43-39-8 (2000) (Georgia law requires licensed psychologists to hold a doctorate degree in a designated field).

¹⁴³ *Ake v. Oklahoma*, 470 U.S. 68, 83 (1985).

¹⁴⁴ Burr et al., *supra* note 7, at 27.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ Burr et al., *supra* note 7, at 57 (citing *Stanley v. Lazaroff*, 2003 WL 22290187 (6th Cir. Oct 3, 2003)).

¹⁴⁸ Feinstein et al., *supra* note 70, at 97.

There may also be a database that lists local psychiatrists and psychologists who are qualified to assess a defendant's competence to stand trial. Check with statewide advocacy organizations such as the Georgia Advocacy Office, the Office of the Mental Health Advocate of the Georgia Public Defender Standards Council, or your regional or local community mental health service provider to see if such a database exists.

Your Responsibilities Regarding the Evaluation

The Georgia rules of discovery apply to all expert witnesses and their reports with respect to competence and insanity evaluations.¹⁴⁹ The court may order the parties to provide the appointed experts with information relevant to a determination of the defendant's competency, including copies of the indictment or information, any supporting documents used to establish probable cause in the case, and any evaluation and treatment or habilitation records. You may also want to tell the evaluator why you think your client is unable to assist you or participate in defending the case.

You should also obtain and submit to the examiner any record or information that the examiner considers necessary for conducting a thorough evaluation on the matters referred. This is a time when you can advocate for the position that is in your client's best interest. Provide the examiner with relevant documents that will help guide the diagnosis. Make sure that the evaluation is conducted promptly after you have suggested that the defendant may be incompetent to stand trial, so that your client does not languish in jail.

Communications between patients and their mental health care providers, including psychiatrists and licensed psychologists, are confidential when a professional relationship has been established.¹⁵⁰ However, Georgia law dictates that this confidentiality will only be recognized where the prerequisite professional relationship exists. The professional relationship in the field of mental health care contemplates treatment will be considered or rendered. The Georgia Supreme Court has ruled, "The requisite professional relationship does not exist when the mental health provider is appointed by the court to conduct a preliminary examination to evaluate a person's mental state because, in such a situation, mental health treatment is not given or contemplated."¹⁵¹ Therefore, you should not consider confidential those communications between your client and court-appointed experts who conduct preliminary competency evaluations of your client.

Preparing the Client for the Evaluation

You need to prepare your client for the competence evaluation. Explain the following matters to your client, using a facilitator if needed;

- The purpose and nature of the examination;
- The potential uses of any disclosures made during the examination;
- The conditions under which the prosecutor will have access to reports and other information obtained for the examination and the reports prepared by the evaluator; and
- The conditions under which the examiner may be called to testify during sentencing.

¹⁴⁹ Ga. Code Ann. § 9-11-26 (1993).

¹⁵⁰ *Id.* at §§ 24-9-21 (1995), 43-39-16 (1986).

¹⁵¹ *State v. Herendeen*, 279 Ga. 323 (2005).

Can You Be Present During the Competence Examination?

Some courts allow counsel to be present during an examination, while others do not. Some allow an attorney to watch, but not to speak. When requesting to be present, acknowledge the concerns of the court and mental health expert, but assure them that you will do nothing to compromise the reliability of the examination. Your presence at the examination enables the evaluating professional to observe the attorney-client relationship and get a better idea about what your client may be asked to do to assist with his or her defense. If the prosecutor initiated the examination, and it is likely that the evaluator will be a State's witness at trial, you may be better able to cross-examine the mental retardation evaluator at trial if you are present during, or have viewed or listened to, the evaluation. However, your presence at the evaluation may inhibit your client from speaking candidly with the evaluator and may also make the evaluation vulnerable to a prosecutor's challenge on cross-examination. If you are not allowed to be present during the evaluation, or decide not to attend, you should inquire about videotaping or audiotaping the interview as an alternative.

FACTORS ADDRESSED IN COMPETENCE REPORTS

The competence report should not contain information or opinions concerning either your client's mental condition at the time of the alleged crime or any statements made by your client regarding the alleged crime or any other crime. Issues of mental competence or insanity at the time of the offense should not be included in the competence report, even if the expert's evaluation deems your client competent. You should ensure that the competence report does not include any offense-related information or express the opinion of the examiner on any questions requiring a conclusion of law or a moral or social value judgment properly reserved for the fact finder.

You may also consider having another attorney interview your client. This attorney should have experience handling similar cases. This legal expert may be able to testify about the level of cooperation that is needed from a client, and whether your client is able to provide that level of cooperation.

CAN YOUR CLIENT "REGAIN" COMPETENCE?

This is a hotly debated issue among advocates for persons with mental retardation. Because mental retardation is a permanent condition, unlike a mental illness, it cannot be "cured." Some states have created programs that attempt to restore competency to individuals with mental retardation. Such programs may have persons with mental retardation participate in mock trials so that they become familiar with court procedure. One such program teaches clients about court processes using a "patient-led" court class in which clients engage in mock trials. The trials are conducted to determine what punishment a person receives when they have broken the hospital's rules for behavior.

While some advocates believe that persons with mental retardation benefit from these programs, others believe they are simply being taught to "parrot" information so that they may be found "competent." If your client is "restored to competence," make sure you determine whether he or she has a better understanding of the process than when deemed "incompetent."

THE SPECIAL JURY

The outcome of a motion for a special plea of mental incompetence may affect how you proceed on the merits of your client's case. The judge may empanel a special jury to determine the issue of your client's competence after conferring with you and the prosecutor.¹⁵² Alternatively, a judge may hold a bench trial to determine the issue of your client's competence if a special jury is not requested. If requested by either party or on motion of the court, the court should empanel a special jury to decide the initial determination of your client's competence.¹⁵³

The following are recommended "next steps" depending on the outcome of the special plea of incompetence determination:

- **If the special jury (or judge) determines that your client is competent**, the case on the merits will proceed according to court procedure. You should further explore all potential defenses, including an insanity defense.
- **If the special jury (or judge) determines your client is incompetent to stand trial**, the court will retain jurisdiction over your client and order your client to undergo an evaluation by the Department of Human Resources on an inpatient or outpatient basis.¹⁵⁴

The Department of Human Resources will evaluate your client for mental competency to stand trial and issue a report to the court. If the client is found mentally competent to stand trial, the client will be returned to the custody of the court. If the Department of Human resources finds the client is incompetent to stand trial, and there is no likelihood of the client regaining mental competency, the Department will report this finding to the court, and it is possible that your client may be held until a hearing is convened if the Department's doctor believes it would be detrimental to release your client. If your client meets criteria for involuntary civil commitment, he or she will be civilly committed for treatment or habilitation on an inpatient or outpatient basis.¹⁵⁵ You should ensure that your client's due process rights are not violated. If your client is charged with committing a nonviolent misdemeanor, he or she can not be held under involuntary civil commitment for any longer than 12 months.¹⁵⁶

- **If your client does not meet civil commitment criteria or becomes competent to stand trial after being committed**, the Department of Human Resources should report this finding to the court and your client will be returned to the custody of the court.¹⁵⁷
- **If your client's preliminary evaluation by the Department of Human Resources finds him or her incompetent to stand trial, but there is a likelihood that mental competence may soon be regained**, the Department of Human Resources should report this finding to the court within 90 days. The Department of Human Resources can then retain your client for treatment for up to 9 months, or, if the criminal charge is a misdemeanor or nonviolent offense, release your client for outpatient treatment. If after 9 months your client is still not competent to stand trial, the court will need to determine whether civil commitment is necessary.¹⁵⁸

¹⁵² *Supra* note 141; Ga. R. Unif. Super. Ct. Rule 31.4.

¹⁵³ *Supra* note 141.

¹⁵⁴ *Id.*

¹⁵⁵ Ga. Code Ann. § 17-7-130(d).

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at § 17-7-130(c).

¹⁵⁸ *Id.* at § 17-7-130(e).

If the Department of Human Resources finds that your client is incompetent to stand trial and that there is no likelihood that treatment would make him or her competent to stand trial in the near future, it should return physical custody of your client to the court, unless the Department's physician recommends otherwise. The court may then order an independent evaluation and report about your client's mental and emotional status. Based on your client's charges and the court's findings after receiving this report, the court will:

- refer the case to the probate court if the charges are dismissed,
- order a hearing to ascertain whether inpatient or outpatient involuntary civil commitment is appropriate and commit your client; or
- release your client in accordance with court procedures for granting bail.¹⁵⁹

If your client is charged with an offense other than a misdemeanor and is civilly committed, he or she has the right to have the case reviewed annually for a determination of whether civil commitment should be renewed.¹⁶⁰ Remember, defendants charged with misdemeanors have the right to be released from civil commitment after one year as a matter of law.¹⁶¹

If it is determined that your client is competent pursuant to the laws of the Official Code of Georgia Annotated, you should prepare the case as you would any other.¹⁶² You should try to secure a trial setting well in advance of your client returning from the regional facility where your client was evaluated. If your client regains competence and decides to go to trial, you should be ready to try the case quickly. It is important to note that a person with mental retardation will not necessarily meet state requirements for civil commitment.

Many criminal court judges may be unaware that dismissed cases are handled differently from cases that have not been dismissed. You may be able to use this distinction to your client's advantage, depending on the court you are in and the seriousness of the alleged offense. For example, a judge who handles misdemeanors may have never conducted a civil commitment proceeding – and may not want to start now. If you can impress upon the judge that a dismissal of your client's case will transfer the responsibility of the civil commitment proceeding to the probate court, the judge might urge the prosecutor to dismiss the case. Your client has the right to receive legal representation if he or she is referred to the probate court for a civil commitment hearing.¹⁶³ The hearing in the probate court will ensue pursuant to the rules of Chapters 3 or 4 of Title 37 of the Official Code of Georgia Annotated.

If your client is going to attend the incompetency trial, you should encourage him or her to behave appropriately in court. You will probably need to have a conversation with your client about what constitutes appropriate behavior.

COURT-ORDERED ADMINISTRATION OF MEDICATION

In *Sell v. U.S.*,¹⁶⁴ the United States Supreme Court held that the government may involuntarily administer antipsychotic drugs to a criminal defendant solely to render him competent to stand trial, at least in those cases meeting the criteria set out by the court. In deciding whether the involuntary medication is appropriate, the court must balance the following factors: (1) whether there is a substantial state interest in having a criminal trial, taking into

¹⁵⁹ *Id.* at § 17-7-130(d).

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Supra* note 135.

¹⁶³ *Id.* at § 17-7-130(d)(1)

¹⁶⁴ *Sell v. U.S.*, 539 U.S. 166 (2003).

account any civil confinement for the mental condition; (2) whether the medication is substantially likely to render the defendant competent without offsetting side effects; (3) whether the medication is necessary or whether a less intrusive alternative procedure would produce substantially the same result; and (4) whether the drugs are medically appropriate.

Georgia law recognizes the right of patients to refuse treatment except when a doctor decides such refusal is unsafe to the patient or to others.¹⁶⁵ This exception is typically applicable to emergency situations. Patients who object to involuntary treatment have the right to petition for a writ of habeas corpus or to request a protective order.¹⁶⁶

¹⁶⁵ Ga. Code Ann. § 37-3-163 (1995).

¹⁶⁶ *Id.* at § 37-3-148 (2000).



SECTION 8

THE INSANITY DEFENSE

While the name of this defense implies that it applies only to persons with mental illness, it may also be used in defending clients with mental retardation based on the premise that a person with mental retardation may not have the capacity to understand right from wrong.¹⁶⁷ An additional premise is that the cause of a defendant's mental retardation may place the defendant in a category whereby an insanity defense would be applicable.¹⁶⁸ The roots of the defense predate the time when there was an understanding of the distinctions between mental illness and mental retardation.¹⁶⁹ Hence, the misnomer.

THE BASICS

A plea of not guilty by reason of insanity (NGRI) is an affirmative defense to prosecution in Georgia. Insanity under the Official Code of Georgia Annotated means that at the time of the act, omission, or negligence constituting the crime, the person did not have mental capacity to distinguish between right and wrong OR if because of mental disease, injury or congenital deficiency, acted because of a delusional compulsion as to such act which overmastered his or her will to resist committing the crime (which is broad enough to encompass mental retardation).¹⁷⁰ To return an NGRI verdict, a jury must find that:

- the prosecution established beyond a reasonable doubt that the defendant committed the alleged act; and
- the defendant established, by a preponderance of the evidence, that he or she was insane at the time of the alleged conduct.

Neither you, the court, nor the prosecutor can inform any juror or prospective juror of the consequences to your client, described below, if a verdict of not guilty by reason of insanity is returned.

You should be very cautious in pursuing the insanity defense. Many potential jurors believe that the defense of insanity is simply an excuse or trick used by defense attorneys to get their clients "off the hook." If you decide to proceed with an insanity defense, you should make sure that your mental retardation expert understands this.

If you are defending your client in a death penalty case, you should also consider the difficulty of convincing the jury that your client was insane for purposes of NGRI, but then having to convince the same jury that the public need not fear the defendant during the punishment phase of the trial if the NGRI defense is not successful.

START BUILDING A CASE EARLY

If you are contemplating an insanity defense, find a reputable mental retardation expert as quickly as you can and have that individual immediately interview your client. Have the interview videotaped if you can.

¹⁶⁷ Ga. Code Ann. § 16-3-2 (1968).

¹⁶⁸ *Id.* at § 16-3-3 (1968).

¹⁶⁹ See W. Lawrence Fitch, *Mental Retardation and Criminal Responsibility*, in *The Criminal Justice System and Mental Retardation* 121, 121-123 (Richard W. Conley et al. eds., 1992).

¹⁷⁰ *Supra* notes 167, 168.

If you can show that your client's insanity will be a significant issue at trial, your client is entitled to obtain expert assistance in preparation of the defense.¹⁷¹ You should file an ex parte motion to the trial court for this expert assistance. A hearing on your client's motion seeking expert assistance must be conducted in secret.¹⁷² You can consult with this expert after he or she has evaluated your client and then make a decision about whether to go forward with the insanity defense. Keep in mind that if you and your client decide not to do so, the prosecutor will know about the evaluation or the expert's findings. Another option is to seek an independent mental health evaluation through other funding avenues. If your client is indigent, you may seek funding through the Georgia Public Defender Standards Council. However, a client who is not indigent may hire his or her own expert to conduct a mental health evaluation. If your client does undergo a private evaluation, the state will not be served notice of potential mental health issues until you are prepared to disclose them.

If you decide to go forward with the insanity defense, and you have opted in to the current discovery statute, Georgia law will require you to disclose the names of all your witnesses, including your mental health expert, and the written mental health evaluation, before trial.¹⁷³ If you are pursuing an insanity defense, you also should know that the court will require your client to submit to another evaluation by a licensed psychologist or psychiatrist.¹⁷⁴

DISPELLING THE MYTH

There is a popular myth that a person who is found not guilty by reason of insanity just walks away. It is true that, like a simple not guilty verdict, an NGRI verdict is considered a full acquittal of all charges. However, unlike a simple not guilty verdict, the court conducts a hearing 30 days after an NGRI verdict to determine whether your client's conduct was "dangerous" and whether there is evidence that the accused has a mental illness or mental retardation¹⁷⁵

- If the evaluation indicates that your client does not meet inpatient civil commitment criteria under Chapters 3 or 4 of Title 37 of the Georgia code, the court may issue an order discharging the defendant from custody without a hearing.¹⁷⁶
- If your client is not discharged, the trial judge should order a hearing to determine whether inpatient commitment is appropriate. If your client meets criteria for inpatient commitment, the court will order physical custody of him or her to be turned over to the Department of Human Resources for involuntary treatment or services as provided by Chapters 3 or 4 of Title 37 of the Official Code of Georgia Annotated.¹⁷⁷
- If your client appears to meet criteria for outpatient involuntary treatment, the court may order a period of conditional release subject to certain conditions and terms set by the court. The court may appoint a community service provider to work with the Department of Human Resources to ensure that your client is complying with the terms of the period of conditional release.¹⁷⁸
- If your client asserts an insanity defense, the court will instruct the jury that they should also consider additional verdicts, including "guilty but mentally retarded." Juries or the court sitting as trier of fact may find a defendant "guilty but mentally retarded" if it is proven beyond a reasonable doubt that the defendant is guilty

¹⁷¹ *Supra* at note 143.

¹⁷² *Brooks v. State*, 259 Ga. 562, 565 (1989).

¹⁷³ Ga. Code Ann § 17-16-8 (1996).

¹⁷⁴ *Id.* at § 17-7-131 (2007)

¹⁷⁵ *Id.* at § 17-7-131(d).

¹⁷⁶ *Id.* at § 17-7-131(e)(1).

¹⁷⁷ *Id.* at § 17-7-131(e)(4).

¹⁷⁸ *Id.* at § 17-7-131(e)(5)(A).

of the crime charged and is a person with mental retardation.¹⁷⁹ Such a defendant will be sentenced in the same manner as persons without mental retardation, unless he or she is convicted of committing a capital offense where the death sentence has been sought. If your client is found “guilty but mentally retarded,” he or she will be sent to state prison and psychiatrically evaluated and given treatment, if necessary. If treatment through the Department of Human Resources is indicated, your client will be temporarily transferred to a Regional facility for treatment. When the treatment is no longer required, your client will be returned to prison.¹⁸⁰

KNOWING THE LAW WILL GIVE YOU A BIG ADVANTAGE

Unfortunately, not only the public at large, but also many judges, defense lawyers, and prosecutors hold a myth surrounding the NGRI verdict. You will have a big advantage if you know the law. For example, if you try your client’s case to the judge, the judge might be reluctant to find your client not guilty by reason of insanity if the judge is operating under the myth that your client will automatically go free upon a NGRI verdict – especially if your client is charged with a violent crime. The judge may feel that a guilty verdict, coupled with probation, will allow your client to get treatment, but will also allow the court to retain some degree of control over your client. By advising the judge that the court can likely both reach a verdict of not guilty by reason of insanity and maintain jurisdiction over your client, you can go a long way toward giving your client a zealous defense.

Knowing the law will also help you and your client decide whether the case should be tried before a judge or a jury. You may want to consider trying your case to the judge instead of a jury because you cannot advise the jury, or jury panel, of the consequences to your client if a verdict of not guilty by reason of insanity is returned. It is highly likely that the jury will be operating under the myth that your client will simply go free if a NGRI verdict is returned and will feel some pressure to return a guilty verdict.

¹⁷⁹ *Id.* at § 17-7-131 (c)(3)

¹⁸⁰ *Id.* at § 17-7-131(g)(1, 2) (2007).



SECTION 9

USE OF EXPERT WITNESSES, MITIGATION, AND SENTENCING STRATEGIES

EXPERT MENTAL RETARDATION WITNESSES

How They Can Help You

Information obtained from mental retardation experts can help you make informed decisions about:

- the manner in which you relate to your client;
- your client's competence to proceed;
- a determination of mental retardation;
- plea negotiations;
- jury selection;
- whether or not your client should testify;
- habilitation or other services for your client while the case is pending;
- the types of assessments or evaluations that are needed; and
- selection of witnesses for the trial, including the penalty phase.

How Can You Get Them?

The incremental approach set out below may not always be practical. Some judges may determine that a misdemeanor case does not warrant the use of an expert witness or that one expert is all you get. This may even be true in some felony cases. Consult with attorneys in your community about how to have experts appointed in your case and whether there are some standard form motions that you can use. Be sure to make a record if the court will not provide reimbursement for the experts or resources you need.

The Incremental Approach – Start With a Mitigation Specialist

When deciding whom to retain as your mental retardation expert(s), you may want to consider first consulting a mitigation specialist, who will often be a licensed social worker. The mitigation specialist will:

- conduct a thorough evaluation;
- interview your client;
- conduct collateral interviews;
- gather your client's records; and
- determine the cultural, environmental, and genetic circumstances that might have factored into your client's case.

Mitigation specialists are superior in many cases to traditional law enforcement investigators in developing mitigating evidence. Mitigation specialists have training in the human sciences and an appreciation for the variety of influences

that may have affected your client's development and behavior. At any rate, the person conducting the investigation should have the training, knowledge, and skills to detect the presence of the following relevant factors:

- mental retardation;
- mental illness;
- neurological impairments;
- other cognitive disabilities;
- physical, sexual, or psychological abuse;
- substance abuse; and
- other influences on the development of your client's personality and behavior.

Mitigation investigations need to be thorough and extensive. If you are defending someone who could receive the death penalty, his or her life quite literally may depend upon your ability to show that he or she is a person with mental retardation. The U.S. Supreme Court has held that failure to investigate such matters in a capital case can constitute ineffective assistance of counsel.¹⁸¹ On the other hand, if your client is charged with a misdemeanor, it may be enough simply to use a social worker mitigation expert, or another qualified investigator, as your only expert in the case.

Keep in mind that you only have to prove the existence of your client's mental retardation, not its cause.¹⁸² The cause of your client's disability may not be identifiable.¹⁸³

Using a Non-testifying Expert as a Consultant

The mitigation expert may then confer with a consulting psychologist (or other mental retardation expert), who will review the records and determine what kinds of expert witnesses you may need and what role you want them to play. If you suspect dual diagnosis, (co-occurring mental retardation and mental illness or substance abuse), or physical or sexual abuse (children with any disability are 3.4 times more likely to be abused than children without disabilities),¹⁸⁴ you may want someone specialized in these areas. The consulting psychologist will refer only specific aspects of your client's case to the testifying experts, who will interview your client in preparation for courtroom testimony.

Expert for IQ Tests

Most psychiatrists are not trained in the proper method of administering IQ tests. You should not assume that a psychiatrist can help you with this phase of an evaluation. A psychologist, social worker, or diagnostician may be better qualified to administer IQ tests.

You may consider having a non-testifying expert other than the consulting psychologist administer the test. This can be helpful because, if you like the result of the test, this person will most likely become a testifying expert. A consultant may be exposed to information during the course of your client's evaluation that you would not want

¹⁸¹ *Wiggins v. Smith*, 539 U.S. 510; *Rompilla v. Beard*, 545 U.S. 374.

¹⁸² *Keyes et al.*, *supra* note 84, at 534.

¹⁸³ *Id.*

¹⁸⁴ *Davis*, *supra* note 33, at 1.

discussed at trial. Having a testifying expert administer the test can backfire for similar reasons – if the results are not favorable, you do not want them discussed during trial.

Focus on Your Testifying Experts

You need to pay attention to the testifying expert's qualifications and select someone who will be credible and persuasive to the court and jury. It is important that testifying experts be forensically trained so that they will have a better understanding of the legal questions that need to be answered. You should thoroughly investigate the expert's background and prior testimony. It is good to have someone who has testified before and knows how to handle cross-examination. If your client's primary language is not English, you may want to consider hiring an expert who is fluent in your client's primary language, if possible. Testifying expert witnesses fall into several categories, and you should pick one who can best meet your needs.

- For testimony related to diagnosis of mental retardation, you should obtain a psychologist or someone who has extensive experience in working with individuals with mental retardation. This may be a psychologist, social worker, or a person who has a degree in education and has focused on special education.
- For testimony related to mental illness, or administering and interpreting tests related to mental illness, you should retain a licensed psychologist or psychiatrist.
- For testimony related to a brain injury or problems with memory, language, or orientation functions (that are not related to mental retardation), you may want to obtain the services of a neuropsychiatrist or neuropsychologist.

You also may want to use a pharmacologist, or specialists in addiction medicine or in sexual trauma, if appropriate. You may want to consult a medical doctor if your client has fetal alcohol syndrome or has been exposed to other toxins, or a neurologist if your client has brain damage.

Local mental retardation professionals may not have the expertise you need. Also, some experts may feel beholden to local authorities for future income. If any circumstances cause you to question the objectivity of the local professional, you should seek expert assistance elsewhere.

Using an incremental approach to developing mitigation evidence may be more cost efficient, more likely to produce information that will advance your theory of the case, and less likely to generate information that will be of no use or, worse, will harm your client. Ideally, the same professional should not fill more than one role. For instance, the same person should not fulfill simultaneous roles of evaluator, non-testifying consultant, treatment provider, or service provider.¹⁸⁵

MITIGATION

Mitigation is not a defense to prosecution. It is not an excuse for committing a crime. It is not a reason the client should "get away with it." Instead, it is evidence of a disability or condition that invites compassion. Mitigation is an explanation of the particular influences that converged in the years, days, hours, minutes, and seconds leading up to the crime; how a person with mental retardation processes information; and the behavior that resulted. Well-presented mitigating evidence can help to describe the "window" through which the client views the world. Each of us views the world through a different window, the size and clarity of which is often determined by factors over which we have no control.

¹⁸⁵ American Bar Association, Criminal Justice Mental Health Standards § 7-1.1 (1989).

Human beings can react punitively toward a person whom they regard as defective, foreign, deviant, or fundamentally different from themselves. A client's behavior or symptoms may be misunderstood by jurors or engender such fear that this behavior becomes an excuse to punish the defendant rather than a basis for mercy. Good mental retardation experts can provide testimony at the punishment phase to help the jury understand who your client is, how he or she experiences the world, and why your client behaves as he or she does. These experts help you humanize your client so that the judge and jury see him or her as a person who deserves empathy and compassion. Your ability to help the jurors reach an empathetic understanding of the circumstances that may have led to your client's behavior can have a profound impact on the sentence. There are few limitations on the evidence that can be offered in mitigation of a crime.¹⁸⁶ However, while a "nexus" is no longer required, mitigation evidence is most persuasive when you are able to show the relationship between the client's disability and the conduct. It is not the "What?" - it is the "So what?" You should explain to the jury not just that your client has mental retardation, but how this affected his or her perspective and behavior. If you cannot answer the "So what?" question that each juror will be asking, the evidence of mental retardation will look like an excuse, not an explanation.

Make sure your expert anticipates some of the common arguments prosecutors make against finding mental retardation.

There are several arguments that prosecutors often raise.

- The defendant is malingering, and "faked" a poor score on an IQ test or tests of adaptive behavior. However, because any definition of mental retardation requires a finding that onset occurred during the developmental period, it is almost impossible to "fake" mental retardation.¹⁸⁷
- The defendant doesn't have any stereotypical behavioral or physical characteristics associated with individuals who have mental retardation, therefore the defendant isn't a person with mental retardation.
- The defendant's behavior is caused by a conduct disorder (anti-social personality disorder is often raised) or substance abuse, not mental retardation.
- The crime was too complex for a person with mental retardation to commit. Most mental retardation experts will say that, unless a crime involves an unusual amount of mental acuity (such as an accounting fraud scheme), the manner in which the crime was committed has little probative value.
- The defendant's disability is not very severe.¹⁸⁸

Prosecutors also commonly rely on outdated or unreliable tests, and use experts who are not trained in mental retardation.¹⁸⁹

SENTENCING STRATEGIES

When thinking about sentencing strategies, there are a number of things you should consider and weigh.

¹⁸⁶ *Tennard v. Dretke*, 542 U.S. 274 (2004).

¹⁸⁷ Edwards, *supra* note 79, at 135.

¹⁸⁸ *Id.* at 136-137.

¹⁸⁹ *Id.*

Mental Retardation Information as Mitigation Can Sometimes Hurt You

You need to consider carefully the decision to raise your client's mental retardation to the jury. Some jurors do not understand mental retardation and may believe that "mild" mental retardation is not a substantial disability. Some jurors may not want your client to be in the community on probation, because they believe the myth that persons with mental retardation are more likely to commit crimes. On the other hand, you must remember that failing to raise the issue of your client's mental retardation may result either in a probated sentence that your client cannot comply with or in a period of incarceration that will further damage your client. As discussed previously, individuals with mental retardation are often victimized in prison.

If you decide to raise your client's mental retardation at the sentencing phase, be sure you have sufficient evidence and expert help. It is not enough to say that your client is mentally retarded. You need to explain how your client's mental retardation affects his or her decision-making and other adaptive skills. Otherwise, jurors may not think that your client's mental retardation is a significant mitigating factor. Remember, the scope of the jury's inquiry at the sentencing phase is much broader than at the guilt or innocence phase. Different types of experts and resources may be helpful. Simply interviewing or submitting your client for a single evaluation almost always will result in an incomplete picture.

You may be better off advising your client to waive a jury and taking the mental retardation evidence directly before the judge. The decision to go to the jury or the judge for sentencing depends on several factors, including the charges involved, the judge, and the prosecutor's willingness to work with you. If your client decides to go to the judge for sentencing and you are seeking probation, you should have a plan for the judge to consider – a stable place for your client to live, a doctor to go to, and programs to provide supervision and help your client stay out of trouble. Be an advocate for your client. Bring in witnesses who know your client, such as a caseworker and family members. If your client is on probation and the state has filed a motion to revoke or a motion to adjudicate guilt, you should call the above-mentioned witnesses to request that the judge not revoke your client's probation or enter a conviction on the record against your client and send him or her to jail.

Ensuring an Accurate and Complete Evaluation

If you are going to bring your client's mental retardation before the judge or jury for sentencing purposes, make sure that the experts you use do more than conduct an evaluation to determine mental retardation and offer a diagnosis. You should work with the experts to ensure that they conduct a wide-ranging inquiry into your client's history and its implications. For example, there may be a family history of mental retardation or a generational pattern of violence and abuse in the home. It is important to interview outside sources, such as family members, former teachers, and physicians, as well as to request all available records. This may be vital to determining adaptive skills and onset before age 18. A comprehensive evaluation should also look for any evidence of dual diagnosis, and should therefore include the following:

- A thorough physical and neurological examination;
- A complete psychiatric and mental status examination if there is any indication of mental illness;
- Diagnostic studies, including personality assessment;
- Neuropsychological testing;
- Appropriate brain scans; and
- A blood test or other genetic studies.

In capital defense litigation, it is especially important to make sure your client has thorough and comprehensive mental examinations that evaluate each area of concern as indicated by the client's bio-psycho-social history.

Recognizing Co-Occurring Substance Abuse Problems

Many persons with mental retardation are addicted to alcohol, other drugs, or both. A client with this problem may have trouble staying clean or being successful on probation. Substance abuse or dependence is a chronic, often relapsing illness that requires treatment. If your client has mental retardation and a substance abuse problem, you should look into the availability of dual diagnosis treatment programs in your community. The Department of Human Resources is responsible for helping individuals receive access to treatment for substance abuse problems in Georgia.¹⁹⁰ A community mental health center or non-profit social service provider may be designated to develop and implement a treatment plan for your client. Some clients would rather accept a plea bargain agreement for jail time than wait to get into substance abuse or dual diagnosis treatment. Your client makes the ultimate decision about whether to get treatment, but you should talk candidly with your client about available treatment options. Talk to your client about doing what is best for him or her over the long term rather than the short term. Again, ask a facilitator to help you with this conversation.

Factoring Mental Retardation Into Probation Decisions

Your client may need special attention if probation is being sought. Remember that your client may not be able to hold down fulltime employment, pay probation fees, keep track of appointments, navigate public transportation, perform community service, or complete schooling the way that other clients can. Special arrangements may need to be made and extra help provided if these tasks are part of the successful completion of your client's sentence. If your client receives probation, you should work to assure that your client gets probation with habilitation or conditions that will help the client successfully complete the probation. If your client is facing probation revocation, you should educate the court about your client's mental retardation and the court's options for conditions of probation.

The judge can order the conditions of probation. Courts may require defendants who are found "guilty but mentally retarded" to receive outpatient medical or psychiatric treatment or voluntary inpatient treatment as a condition of probation.¹⁹¹ Your client may have to pay probation fees as well as fees for receiving treatment or habilitation services.¹⁹² The court has a great deal of flexibility to tailor the appropriate conditions of treatment for your client. In addition, the court can amend the terms of probation to reflect improvements or deterioration in your client's condition. Again, it is important to discern whether your client has the capability to comply with any probation conditions that may be imposed by the court before you seek probation.

Specialized probation caseloads are an important option. If your local probation department has specialized caseloads for adults with mental illness or mental retardation, you should ask that your client be placed on such a caseload. The officers who work in these special units usually have received extra training about mental retardation and mental illness and monitor a smaller number of clients. Bring your client's mental retardation to the attention of both the judge and the probation department. Tell the probation department that your client has special needs and seek accommodations for your client through the probation department. If you think that your client may deteriorate soon after being placed on probation, ask the probation department if it will authorize an evaluation. Sometimes this

¹⁹⁰ Ga. Code Ann. §§ 37-2-1 (2002), 37-7-120 (1978).

¹⁹¹ *Id.* at § 17-7-131(h).

¹⁹² *Id.* at § 42-8-34 (2005).

can be done before the plea, in which case you can use the results of this evaluation to further negotiate probation terms for your client.

Your Client May Not Want Treatment or Habilitation

You cannot force your client to get habilitation if it is not desired, even though you know it may be in your client's long-term interest. You may be limited in what you can do for your client. If your client's charges are minor and the client has a supportive family, has a safe place to live, is usually relatively stable, and is competent, it may be better for your client to plead to jail time if you can negotiate a good deal rather than to pursue an insanity defense (if applicable), or to accept a probated sentence. However, you have an obligation to set out all the pros and cons of any plea bargain agreement for your client. If your client is considering straight jail time, you should discuss the possible benefits of taking probation with conditions that require habilitation. Discuss your client's chances of staying out of trouble if habilitation is not chosen, and explain the penalties for committing another offense.

GO THE EXTRA MILE FOR YOUR CLIENT

Persons with mental retardation who are not linked with appropriate services at sentencing are likely to commit another offense, perhaps with more serious consequences and penalties attached to the second or third arrest.¹⁹³ Try to enlist the aid of ongoing habilitation services that will help your client stay out of trouble. If your client is being released on probation, stable housing is especially important. Talk with the probation department about the resources it uses. Call the local chapter of The Arc, The Georgia Advocacy Office, The Office of the Mental Health Advocate of the Georgia Public Defender Standards Council, or the local community mental health board or MHDDAD center for recommendations about services. Additional resources that may be able to offer you guidance are listed at the end of this manual.

¹⁹³ Petersilia, *supra* note 77.



SECTION 10

ATKINS: A SHORT SUMMARY AND LIST OF RESOURCES

In *Atkins v. Virginia*,¹⁹⁴ the United States Supreme Court held that the execution of persons with mental retardation constitutes cruel and unusual punishment in violation of the Eighth Amendment to the United States Constitution. Writing for the majority, Justice Stevens determined that executing defendants with mental retardation did not further the two basic rationales for the death penalty – retribution and deterrence.¹⁹⁵ His reasoning was based on the assumption that the death penalty should be reserved for the most morally culpable in our society.¹⁹⁶ Because persons with mental retardation suffer from disabilities in reasoning, judgment, and control of their impulses, the Supreme Court held that they do not act with the level of moral culpability that characterizes the “most serious adult criminal conduct” and that their “impairments can jeopardize the reliability and fairness of capital proceedings against mentally retarded defendants.”¹⁹⁷ Stevens wrote, “If the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State, the lesser culpability of the mentally retarded inmate surely does not merit that form of retribution.”¹⁹⁸ The Supreme Court also recognized the increased risk of false conviction faced by defendants with mental retardation.¹⁹⁹

Though the Supreme Court’s holding extends to all defendants who “fall within the range of mentally retarded offenders about whom there is a national consensus,” it left the task of fashioning a definition of mental retardation to the states.²⁰⁰ However, states cannot adopt a definition that encompasses a smaller group of defendants than that set out in *Atkins*.²⁰¹

Georgia Law, Mental Retardation, and the Death Penalty

Attorneys who represent clients charged with committing capital felonies for which the death penalty is sought require a specific set of litigation skills that cannot be adequately defined in this manual. Additional factors must be considered when the client is a person with mental retardation. However, there is basic information about Georgia law that you should be aware of as you determine how to best move forward with representing a client with mental retardation who could receive the death penalty.

The execution of persons with mental retardation is cruel and unusual punishment under the Georgia Constitution. Georgia was among the first states to ban the death penalty against persons with mental retardation through legislative action. Its law, a forerunner to the *Atkins* decision, is applicable to death penalty cases that commenced on or after July 1, 1988.²⁰²

In Georgia, criminal defendants who contend they were insane or mentally incompetent at the time of the crime they are charged with committing may receive verdicts of “guilty”, “not guilty”, “not guilty by reason of insanity at the time

¹⁹⁴ *Atkins v. Virginia*, 536 U.S. 304 (2002).

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.* at 306-07.

¹⁹⁸ *Id.* at 319.

¹⁹⁹ *Id.* at 320-321.

²⁰⁰ *Id.* at 317.

²⁰¹ James W. Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues* 5, in materials from The Center for American and International Law’s presentation of Capital Trial Advocacy and Mental Retardation – *Atkins* and Beyond, Austin, Texas (October 28, 2002).

²⁰² Ga. Code Ann., § 17-7-131(j) (2007).

of the crime”, “guilty but mentally ill at the time of the crime” or “guilty but mentally retarded.”²⁰³ The jury or court acting as trier of fact must find beyond a reasonable doubt that the defendant is guilty of the crime and is a person with mental retardation.²⁰⁴ If the defendant’s trial is a capital trial, a life sentence, rather than the death penalty, will be imposed if the defendant is ultimately found “guilty but mentally retarded.”²⁰⁵ If the issue of mental retardation is not raised at a capital trial where the defendant is sentenced to death, the defendant can file a habeas corpus petition to raise the issue under the “miscarriage of justice” exception to Georgia court procedure rules.²⁰⁶

Indigent Defense in Capital Trials

Many defendants with mental retardation who are charged with capital felonies may also be indigent. The Georgia legislature has established the Office of the Georgia Capital Defender (Office). This Office, a successor to the Office of the Multicounty Public Defender, is responsible for defending indigent defendants accused of committing capital felonies for which the death penalty is being sought.²⁰⁷ County superior courts must notify the Office about indigent defendants who require representation in death penalty cases. If the Office is unable to represent the defendant, the presiding judge of the court where the case has been brought must appoint counsel to represent the defendant.²⁰⁸ A recent amendment to Georgia law restricts the number of court-appointed, state-compensated counsel to two attorneys in such cases; however, the presiding judge may appoint one additional attorney if the county agrees to provide funding for that attorney.²⁰⁹ The Office provides training and other forms of assistance to attorneys who represent clients accused of committing crimes for which the death penalty is being sought. More information about the Office and its resources can be found at <http://www.gacapdef.org/main.htm>.

PUTTING *ATKINS* INTO PRACTICE

This handbook is not an exhaustive resource for attorneys who represent clients with mental retardation in capital cases – it is merely a starting point. Space limitations keep us from fully analyzing the myriad issues that surround the complexity of *Atkins* and its implications for practice in Georgia.

ADDITIONAL RESOURCES

Materials in Print

The American Bar Association (various publications relating to the Supreme Court’s decision in *Atkins*, available on its website, www.abanet.org).

Richard Burr et al., *A Practitioner’s Guide to Defending Capital Clients Who Have Mental Retardation* (2004).

The Center for American and International Law, materials from presentation entitled “Capital Trial Advocacy and Mental Retardation – *Atkins* and Beyond” (October 28, 2002).

Victor R. Scarano & Bryan A. Liang, *Mental Retardation and Criminal Justice: Atkins, the Mentally Retarded, and Psychiatric Methods for the Criminal Defense Attorney*, 4 Hous. J. Health L. & Pol’y 285 (2004).

²⁰³ *Id.* at § 17-7-131(c).

²⁰⁴ *Id.* at § 17-7-131(c)(3); *Perkinson v. State*, 279 Ga. 232, 234 (2005).

²⁰⁵ Ga. Code Ann. § 17-7-131(j).

²⁰⁶ *Id.* at § 9-14-48(d); *Head v. Stripling*, 277 Ga. 403, 409-410 (2003).

²⁰⁷ *Id.* at § 17-12-121.

²⁰⁸ *Id.* at § 17-12-127.

²⁰⁹ *Id.*

Advocacy Groups/Experts

Office of Georgia Capital Defenders
www.gacapdef.org
(404) 739-5151

Capital Defense Network
www.capdefnet.org

The Center for American and
International Law
<http://www.cailaw.org/ils.html>
(for CLEs focused on Capital Trial Advocacy)

Human Rights Watch
www.hrw.org
(312)-573-2450

The International Justice Project
www.internationaljusticeproject.org

The Justice Project
www.thejusticeproject.org
info@thejusticeproject.org

Southern Center for Human Rights
www.schr.org
(404) 688-1202

The American Bar Association
www.abanet.org
1-(800) 285-2221

Georgia Innocence Project
www.ga-innocenceproject.org
(404) 872-8236

Death Penalty Information Center
www.deathpenaltyinfo.org
(202) 289-2275

Office of Defender Services (Federal)
www.fd.org
1-(800) 788-9908



SECTION 11

CRITICAL INFORMATION ABOUT DEFINITIONS AND DIAGNOSIS

Understanding the definition of mental retardation is important to your client's case. This is particularly true if your client could receive the death penalty. While you should have an expert witness explain the definition to the jury, you should also be conversant with the definitions. A good understanding of the definitions will guide your investigation and the strategy for your client's case.

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

According to the DSM-IV-TR, the definition of mental retardation has three components:

1. Significantly sub-average intellectual functioning (IQ of approximately 70 or below on individually administered test);
2. 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
3. Onset before age 18.²¹⁰

In addition, the DSM-IV-TR sets out the following diagnostic categories:

- Mild Mental Retardation – IQ level of 50-55 to approximately 70 – can usually achieve social and vocational skills adequate to minimum self-support, but may need guidance and assistance when under unusual social or economic stress.
- Moderate Mental Retardation – IQ level of 35-40 to 50-55 – may achieve self-maintenance in unskilled or semi-skilled work under sheltered conditions, but need supervision under mild social or economic stress.
- Severe Mental Retardation – IQ level of 20-25 to 35-40 – may contribute partially to self-maintenance under complete supervision and can develop self-protection skills to a minimal useful level in a controlled environment.
- Profound Mental Retardation – IQ below 20 or 25 – may have some motor and speech development and may develop some very limited self-care, but usually need nursing care.²¹¹

THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (formerly the American Association on Mental Retardation)

The AAMR, a 2002 publication of the American Association on Intellectual and Developmental Disabilities (AAIDD), (this organization was formerly known as the American Association on Mental Retardation (AAMR)), sets out a similar definition:

- Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical skills. This disability originates before age 18.²¹²

²¹⁰ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 46 (4th ed., text revision 2000).

²¹¹ *Id.*

The AAMR defines “adaptive behavior” as the collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives.²¹³ It gives the following examples of conceptual, social, and practical skills:

- Conceptual Skills – language, reading and writing, money concepts, and self-direction.
- Social Skills – interpersonal skills; responsibility; self-esteem; gullibility (likelihood of being tricked or manipulated); naïveté; ability to follow rules, obey laws, and avoid victimization
- Practical Skills –
 - Activities of daily living, including eating, transfer/mobility, toileting, dressing;
 - Instrumental activities of daily living – meal preparation, housekeeping, transportation, taking medication, money management, telephone use;
 - Occupational skills;
 - Maintains safe environments.²¹⁴

Finally, the AAMR lists five assumptions that it finds essential to the application of its definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture. This means that the standards against which the individual's functioning must be measured are typical community-based environments, not environments that are isolated or segregated by ability. Typical community environments include homes, neighborhoods, schools, businesses, and other environments in which people of similar age ordinarily live, play, work, and interact. The concept of age peers should also include people of the same cultural or linguistic background.
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors. This means that, in order for assessment to be meaningful, it must take into account the individual's diversity and unique response factors. The individual's culture or ethnicity, including language spoken at home, nonverbal communications, and customs that might influence assessment results, must be considered in making a valid assessment.
3. Within an individual, limitations often coexist with strengths. Like all people, individuals with mental retardation often do some things better than other things. Individuals may have capabilities and strengths that are independent of their mental retardation. These may include strengths in social or physical capabilities, strengths in some adaptive skill areas, or strengths in one aspect of an adaptive skill in which they otherwise show an overall limitation.
4. An important purpose of describing limitations is to develop a profile of needed supports. This means that merely analyzing someone's limitations is not enough, and that specifying limitations should be a team's first step in developing a description of the supports the individual needs in order to improve functioning. Labeling someone with the term mental retardation should lead to a benefit such as a profile of needed supports.
5. With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve. A lack of improvement in functioning can serve as a basis for reevaluating the profile of needed supports. In rare circumstances, however, even appropriate supports may merely

²¹² AAMR, *supra* note 10, at 1.

²¹³ *Id.* at 73.

²¹⁴ *Id.* at 42.

maintain functioning or stop or limit regression. The important point is that the old stereotype that persons with mental retardation never improve is incorrect. Improvement in functioning should be expected from appropriate supports, except in rare cases.²¹⁵

CONSIDERING THE TWO DEFINITIONS

There are some subtle differences in the two definitions of mental retardation outlined above:

- The DSM-IV-TR requires “significantly sub-average IQ” and “concurrent deficits” in adaptive behavior, while the AAMR requires “significant limitations” in IQ and adaptive skills. In practice, this may be a distinction without a difference.
- The DSM-IV-TR requires deficits in two of the 11 adaptive skill areas, while the AAMR requires deficits in only one adaptive skill domain.
- The APA still uses the “mild, moderate, severe, profound” classifications, which the AAMR has abandoned.
- The AAMR includes the five assumptions that it considers “essential” to the application of its definition.

In practice, using either of these two definitions may produce the same results. However, it is important to understand the distinctions between the two and to acknowledge that different experts may use different definitions. Be sure to determine which definition your evaluator uses so that you will have a clear understanding of the paradigm that is being applied to your client. There is, on some level, a difference in perspective between the two definitions. The APA’s DSM-IV-TR attempts to provide diagnostic criteria to improve the reliability of diagnostic judgments of “mental disorders” so that clinicians can diagnose, communicate about, study, and treat people with these disorders.²¹⁶ The AAIDD (formerly AAMR) definition is that of a professional group whose principal focus is advancing a “fuller understanding of the condition of mental retardation” and creating a “support paradigm” that will allow individuals with mental retardation to lead fuller, more inclusive lives.

Some defense counsel also report having found the DSM-IV-TR definition easier to use when trying to persuade a jury that a client has mental retardation. These attorneys note that the DSM-IV-TR formulation only requires that you prove deficits in two areas of adaptive behavior. The AAMR definition is not as clear in its requirement of “substantial limitations” in adaptive behavior. It may be easier for a jury to identify limitations in adaptive behavior under the DSM-IV-TR definition. The jury may be convinced that the evidence is even stronger if you can show deficits in more than two areas. However, the same practitioners also note that the AAMR is clearer in its discussion of the SEM, and in showing that IQ scores above 70 do not necessarily foreclose a diagnosis of mental retardation.

DIAGNOSIS OF MENTAL RETARDATION

The three criteria used in determining whether someone has mental retardation were discussed in Section 1. However, you should be familiar with the different diagnostic instruments, the methods of evaluation, and the problems associated with each.

²¹⁵ *Id.* at 8.

²¹⁶ American Psychiatric Association, *supra* note 210.

IQ Tests

Testing Expert

Assessing intellectual functioning requires specialized professional training.²¹⁷ Clinical psychologists, neuropsychologists, and certified diagnosticians are best trained to carry out IQ tests. Psychiatrists do not usually carry out IQ tests, since they rarely have training in this area.²¹⁸ Finding an expert who has a great deal of experience administering IQ tests is very important, since there can be errors in both administering and grading a test that can affect your client's score.

You may find it beneficial to use different experts for IQ testing and testing other aspects of mental retardation, such as adaptive behavior. A psychologist may be able to administer an IQ test, but may not have experience and expertise in working with individuals with mental retardation.²¹⁹ As discussed in Section 9, your mitigation expert should be someone who has a wealth of experience in working with individuals who have mental retardation.

Some Tests are Better than Others

Some tests are considered **inadequate** for purposes of ruling out a diagnosis of mental retardation.²²⁰ These tests are:

- the Kaufman Brief Intelligence Test;
- the Revised Beta;
- the Lorge-Thorndike Intelligence Test;
- the Peabody Picture Vocabulary Test; and
- Any group-administered test.²²¹

It is not uncommon for a prosecution expert to use one of these tests, and then argue that its result shows that your client does not have mental retardation. It is very important for you to investigate the prosecution expert carefully, along with the test the expert administered to your client. You may want to consider the following recommendations.

- Attend the evaluation, if possible.
- Review all data.
- Determine whether the expert relies on old tests that may not be accurate.
- Do not assume every test is scored correctly.
- Always review the expert's prior testimony and hearings transcripts.
- Determine whether the expert relies too heavily on IQ test scores, ignoring adaptive behavior deficits.

²¹⁷ *Id.* at 51.

²¹⁸ Burr et al., *supra* note 7, at 27.

²¹⁹ *Id.*

²²⁰ William J. Edwards, *Working with Clients with Special Needs (Intellectual Disabilities) and Other Developmental Disabilities* 3 (citing *Opening the Door, Justice for Defendants with Mental Retardation*, note 229, at 68 (1st ed., Texas Appleseed (2005))).

²²¹ *Id.*

- Determine whether the prosecutor's expert intends to rely on the Minnesota Multiphasic Personality Inventory (MMPI), which is inappropriate for use with persons with mental retardation.²²²

The tests that are most reliable are the **Wechsler** scales and the **Stanford-Binet**.²²³ There is a series of Wechsler tests, developed for different developmental phases. For adults, the Wechsler test is the Wechsler Adult Intelligence Scale – III (WAIS-III). This test and the Stanford-Binet V are considered to be "the most reputable and reliable test instruments available."²²⁴ Others include the Kaufman Adolescent and Adult Intelligence Test (KAIT) in the list of reliable tests.²²⁵ A clinician should determine which test is most appropriate based on the personal characteristics of the client being tested.²²⁶

Testing conditions should also be considered. Trained administrators must administer IQ tests under the proper conditions to ensure that accurate scores are obtained.²²⁷

When you are evaluating old test scores, you may want to keep the following questions in mind:

- What was the context for the testing? School, prison, jail, military?
- What was the environment like?
- Was it part of school placement or evaluation?
- What were the motives/biases of the evaluators in that context?
- How old was the test when it was given?
- What was the SEM for the test?
- What was the educational background of the evaluator?
- Was the evaluator qualified to administer the test?
- Has your client ever taken the same examination or test before?
- Did the administration of the test comport with the minimum requirements for an appropriate assessment of general intellectual functioning?
- If you have never heard of the test that was administered, get a copy of *Buros Mental Measurement Yearbook*.²²⁸ It covers every test ever written.²²⁹

²²² *Id.* at 7. For more information on the inappropriate use of the MMPI to identify malingering in defendants with mental retardation, see Denis William Keyes, *Use of the Minnesota Multiphasic Personality Inventory (MMPI) to Identify Malingering Mental Retardation*, 42 *Mental Retardation* 151-53 (2004).

²²³ *Id.* at 59

²²⁴ Burr et al., *supra* note 7, at 28.

²²⁵ Edwards et al., *supra* note 79, at 80.

²²⁶ AAMR, *supra* note 10, at 58.

²²⁷ Burr et al., *supra* note 7, at 20.

²²⁸ More information about this handbook can be obtained on the internet at <http://www.unl.edu/buros/> (Last visited July 2007).

²²⁹ Edwards, *supra* note 220, at 4.

Should I Have My Client Tested?

This is always an important question to ask when you begin your assessment. If there are reliable “old” test scores that place your client within the range that would provide a diagnosis of mental retardation, you may not want to have the client retested. There is always the danger that your client could score higher on a subsequent test.²³⁰

This is particularly true if your client has been tested recently – some evaluators say there is a risk that a person may score higher on a test that is taken shortly after the preceding test. This is known as the “**practice effect.**”²³¹ **If your client is retested, using the same IQ test, shortly after the initial test, the second score should be read taking the “practice effect” into account.**²³² The practice effect can occur across different editions of IQ tests, and may last for as long as six months after a test has been given. If your client has been tested within the last six months, discuss the “practice effect” thoroughly with your experts before you have your client tested again.

Scores

IQ tests provide a rough numerical assessment of present level of intellectual functioning compared to others.²³³ The criterion for diagnosis is approximately two standard deviations below the mean, considering the standard error of measurement for the specific assessment instruments used and the instruments’ strengths and limitations.²³⁴ The SEM is generally estimated to be three to five points for well-standardized measures of general intellectual functioning.²³⁵ An IQ score is therefore best seen as bounded by a range of approximately three to four points above and below the obtained score. This means that an IQ of 70 is not accurately understood as a precise score, but would instead be considered a range of confidence with parameters of at least one SEM (scores of about 66 to 74; 66 percent probability), or two SEM’s (scores of 62 to 78; 95 percent probability).²³⁶

When an IQ test is given, the test administrator should be sensitive to the array of factors that could influence or invalidate the evaluation, including the defendant’s history as it affects his or her current physical and psychological state, attitude toward the test, and hidden motivations.²³⁷ For example, a defendant could be experiencing culture shock because of being incarcerated for the first time, or could be going through detoxification as a result of problems with substance or alcohol addiction.²³⁸

The “**Flynn effect**” should also be taken into account when determining scores. James Flynn, a professor in New Zealand, was the first to document massive IQ gains in populations over time. His research shows that during the last century, scores on standardized measurements of intelligence have been rising steadily in the U.S. and throughout the world. Essentially, Flynn’s research indicates that test scores must be adjusted according to the gain in IQ since the test was last “normed.” This normalization is similar to the process of using the consumer price index to account for inflationary changes in the value of a dollar at different points in time. For more information about the “Flynn effect”, see Flynn’s description in the affidavit on the Georgia Appleseed website at <http://www.gaappleseed.org> and on the CD at the back of this handbook. The “practice effect,” discussed above, should also be considered.

²³⁰ See *id.* at 35 (discussing divergent scores).

²³¹ *Id.* at 34.

²³² *Id.*

²³³ Human Rights Watch, *supra* note 13, at 1.

²³⁴ AAMR, *supra* note 10, at 14.

²³⁵ *Id.* at 57.

²³⁶ *Id.*

²³⁷ Hall, *supra* note 22, at 174.

²³⁸ *Id.*

There is no fixed “cutoff” score for an assessment of mental retardation.²³⁹ This is a particularly important point given that scores will vary depending upon the test that is used.²⁴⁰ For example, a score of 70 on a Wechsler scale will identify 2.29% of the population as potentially having mental retardation, whereas a Stanford-Binet-IV score of 70 identifies slightly more than 3% of the population as eligible for a determination of mental retardation.²⁴¹ In the United States, the difference between these two would be meaningful, approximately 2 million people.²⁴²

Adaptive Behavior

Both the DSM-IV-TR and the AAMR recognize that, in addition to limitations in intelligence, a person with mental retardation experiences limitations in adaptive behavior. The AAMR defines “significant limitations” as performance that is at least two standard deviations below the mean of either (a) one of the following three types of behavior: conceptual, social, or practical; or (b) an overall score on a standardized measure of conceptual, social, and practical skills.²⁴³

The AAMR lists several assumptions about adaptive behavior that it deems relevant to diagnosis. Some of these assumptions are as follows:

- Adaptive behavior is a multi-domain construct.
- No existing measure of adaptive behavior completely measures all adaptive behavior domains.
- For a person with mental retardation, adaptive behavior limitations are generalized across domains of conceptual, social, and practical skills.
- Some adaptive behaviors are particularly difficult to measure using a rating scale or are not contained on existing standardized instruments.
- Low intellectual abilities may be responsible for both problems in acquiring adaptive behavior skills (acquisition deficit) and with the appropriate use of skills that have been learned (performance deficit).
- Assessment that provides information about typical behavior for the individual requires information that goes beyond what can be observed in a formal testing situation.
- Just as standardized measures of intelligence do not fully reflect what is considered “intellectual capacity,” it is unlikely that a single standardized measure of adaptive behavior can adequately represent an individual’s ability to adapt to the everyday demands of living independently.
- Problem behavior that is “maladaptive” is not a characteristic or dimension of adaptive behavior, as conceptualized in the 2002 definition of mental retardation. However, problem behavior may influence the acquisition and performance of adaptive behavior.
- Adaptive behavior must be examined in the context of the developmental periods of infancy and early childhood, childhood and early adolescence, late adolescence, and adulthood.

²³⁹ *Id.* at 58.

²⁴⁰ *Id.*

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ AAMR, *supra* note 10, at 76.

- Adaptive behavior scores must be examined in the context of the individual's own culture, which may influence opportunities, motivation, and performance of adaptive skills.²⁴⁴

Some Instruments are Better than Others

It is important to understand the major purpose that underlies the use of adaptive behavior measures. These instruments were primarily intended to determine skill levels for purposes of program placement. They were not intended to be used in criminal cases. As a result, the use of these measures in criminal cases warrants caution and requires the acquisition of other sources of adaptive behavior information (interviews, records review).

Some adaptive behavior instruments, such as the Street Skills Survival Questionnaire (SSSQ), are inadequate for purposes of ruling out a diagnosis of mental retardation. While an instrument like the SSSQ has features that are attractive (for example, performance indicator of adaptive skills), this type of scale is not a comprehensive measure of adaptive skills.

As previously stated, it is very important for you to investigate the prosecution expert carefully, along with the adaptive behavior measure the expert administered to your client. Consider the following recommendations:

- Review all data.
- Do not assume every adaptive behavior measure is scored correctly.
- Always review the expert's prior testimony and hearings transcripts.
- Make sure that individuals (lay witnesses) who respond to the adaptive behavior instrument are credible.
- Make sure that at least one of the lay witnesses is from your client's same cultural or ethnic background.

Testing conditions should also be considered. A person who has experience in conducting tests for measures of adaptive behavior should administer the test to ensure testing and scoring accuracy. The scores obtained from formal measures of adaptive behavior typically include standard scores (mean = 100; standard deviation = 15), scaled scores (mean = 10; standard deviation = 3), and percentile ranks. When you are evaluating old adaptive behavior scores, you may want to keep the following questions in mind.

- How was the measure administered?
- Was it administered to a knowledgeable informant? Self-report?
- What was the context for obtaining responses? Pre-age 18? At time of crime? Other?
- Was it part of school placement or evaluation?
- What were the motives/biases of the evaluators in that context?
- How old was the instrument when it was given?
- Which norms were used? Some instruments have norms for individuals who are normal and norms for individuals with mental retardation.
- What was the SEM for the test?
- Was the evaluator qualified to administer the instrument?

²⁴⁴ *Id.* at 74-75.

If you have never heard of the test that was administered, get a copy of Buros Mental Measurement Yearbook, which includes a definitive listing.²⁴⁵

Standardized Instruments for Measuring Adaptive Behavior

There are several established standardized instruments used to measure adaptive behavior. They include the Adaptive Behavior Assessment System-II, the Vineland Adaptive Behavior Scales, the Scales of Independent Behavior – Revised, the AAMR Adaptive Behavior Scales, and the Comprehensive Test of Adaptive Behavior – Revised.²⁴⁶ Each of these instruments measures some adaptive behavior in all three domains.²⁴⁷ However, certain skills that are indicative of mental retardation are not covered by any of these measurement instruments.²⁴⁸ This makes it particularly important to include a comprehensive life history as part of the assessment of adaptive behavior.²⁴⁹ (See Section 4 for a discussion of the type of information that should be reviewed as a part of this process.)

Issues in Assessing Adaptive Behavior

- Adaptive behavior information should be obtained from multiple sources. This includes formal standardized assessments as well as information obtained from interviews and reviewing records. One test score is not sufficient. You need information about adaptive behavior from multiple sources.
- In assessing adaptive behavior, the AAMR clearly indicates that you must take the context in which the person was evaluated into account. For example, a person may function well, and therefore assess better, while living in a more structured environment. If your client scored well on a measure of adaptive behavior in the past, but does not score well now, you should determine whether he or she was living in a more structured, “atypical” environment at the time of the first test.²⁵⁰
- Prison is a highly structured environment. Certain aspects of your client’s adaptive behavior will appear better because of the structure of prison confinement. Prison is not a good indicator of what your client’s adaptive behavior skills are in a “real world” setting, as many adaptive skills areas are not used nor can they be assessed.
- Most instruments do not measure certain traits that are directly related to mental retardation, like gullibility and naïveté, as discussed above.
- If the client was not tested prior to age 18, your mitigation specialist will have to recreate an adaptive behavior history using records and personal interviews – often referred to as “retrospective assessment.” Questionnaires developed for this purpose are included on the Georgia Appleseed website at <http://www.gaappleseed.org> and on the CD at the back of this handbook.
- Lay witnesses (family members, friends, employers, teachers) providing information on adaptive behavior must be credible and ultimately willing to sign an affidavit or testify.

²⁴⁵ Edwards, *supra* note 220, at 4.

²⁴⁶ *Id.* at 88-91.

²⁴⁷ Burr. et al., *supra* note 7, at 29.

²⁴⁸ *Id.*; AAMR, *supra* note 10, at 74, 84; Stephen Greenspan & Harvey N. Switzky, *Lessons from the Atkins Decision for the Next AAMR Manual*, in *What is Mental Retardation? Ideas for an Evolving Disability Category* (2006), (citing *Opening the Door: Justice for Defendants with Mental Retardation*, note 203, at 60 (1st ed., Texas Appleseed (2005)).

²⁴⁹ AAMR, *supra* note 10, at 74, 84.

²⁵⁰ Burr et al., *supra* note 7, at 37.

- Lay witnesses providing information on adaptive behavior should have the following qualifications: (a) frequent contact with the individual; (b) contacts of long duration; (c) opportunities to observe the variety of adaptive skills; and (d) recent contact.²⁵¹ Note: The last criterion is not possible in cases where your client has been incarcerated for a significant period of time. As a result, if no other adaptive behavior data exist prior to age 18, the use of retrospective assessment may be the only option.
- At least one of the lay witnesses providing information on adaptive behavior should be of the same cultural or ethnic group as your client.
- The scores on a standardized measure of adaptive behavior are invalid if an excessive amount of guessing (as indicated in the test administration manual) on levels of adaptive functioning occurs.

Onset Before Age 18

As discussed above, the age of onset may be one of the more difficult aspects of determining mental retardation if you represent a client over the age of 18 who has never been assessed. The best way to find evidence of onset before age 18 is to comb through the records discussed in Section 4, and to interview people using background questions like those that can be viewed on the Georgia Appleseed website at <http://www.gaappleseed.org> and on the CD at the back of this handbook. A mitigation specialist who can help you compile this information will be an invaluable resource.

²⁵¹ Patti L. Harrison & Thomas Oakland, *Adaptive Behavior Assessment System Manual 15* (2d ed. 2003)



RESOURCES

Family Resources

The Georgia Advocacy Office
1-(800) 537-2329 or (404) 885-1234
<http://www.thegao.org>

The Governor's Council on Developmental Disabilities
1-(888) 275-4233
<http://www.gcdd.org>

The Arc of Georgia
(404) 657-8904
<http://www.thearcofgeorgia.org>

The Arc of Carroll County, Inc.
(770) 834-6232

The Arc of Telfair County
(229) 868-0023

Arc – Macon
(478) 477-7764
<http://www.arc-macon.org>

Institute on Human Development and Disability
University of Georgia
(706) 542-3457
<http://www.ihdd.uga.edu>

Division of Mental Health, Developmental Disabilities, and Addictive Diseases; (MHDDAD)

Behavioral Health Link: 1-800-715-4225 (to get information about obtaining mental health and addictive diseases services from MHDDAD offices throughout Georgia)

Metropolitan Atlanta MHDDAD numbers:
(404) 657-2258, (404) 657-5737,
(404) 463-8037
<http://www.mhddad.dhr.georgia.gov>

Atlanta Alliance on Developmental Disabilities
The Aging and Disability Resource Connection
(404) 881-9777, ext. 223
<http://www.aadd.org>

The Arc of the United States
(301) 565-3842, 1-(800) 433-5255
<http://thearc.org>

Arc of Walker County
(706) 638-0962

Newnan-Coweta Arc
(770) 253-1189
<http://www.rutledgecenter.org>

MHDDAD Regional offices provide community habilitation and support services, Medicaid waivers, and other services for clients with intellectual disabilities and their families. Contact your regional office to obtain information about service providers for persons with intellectual and developmental disabilities.

**Regional MHDDAD contact numbers for Counties Served:
developmental disabilities services**

Region 1

Regional Office: 1-(800) 646-7721, (706) 802-5272
Intake and Evaluation team: 1-(877) 217-4462, (770) 387-5440

Bartow County, Butts County, Carroll County, Catoosa County, Chattooga County, Coweta County, Dade County, Fanin County, Floyd County, Gilmer County, Gordon County, Haralson County, Heard County, Lamar County, Meriwether County, Murray County, Paulding County, Pickens County, Pike County, Polk County, Spalding County, Troup County, Upson County, Walker County, Whitfield County

Region 2

Regional Office: 1-(866) 380-4835, (706) 792-7733
Intake and Evaluation team: 1-(877) 551-4897, 706-792-7741

Banks County, Barrow County, Burke County, Clarke County, Columbia County, Dawson County, Elbert County, Hancock County, Glascock County, Greene County, Forsyth County, Franklin County, Habersham County, Hall County, Hart County, Jackson County, Jasper County, Jefferson County, Jenkins County, Lincoln County, Lumpkin County, Madison County, McDuffie County, Morgan County, Newton County, Oconee County, Oglethorpe County, Richmond County, Rabun County, Screven County, Stephens County, Taliaferro County, Towns County, Union County, Walton County, Warren County, Washington County, White County, Wilkes County

Region 3

Regional Office: (770) 414-3052
Intake and Evaluation team: (770) 414-3052

Clayton County, Cherokee County, Cobb County, DeKalb County, Douglas County, Fayette County, Fulton County, Gwinnett County, Henry County, Rockdale County

Region 4

Regional Office: 1-(877) 683-8557, (229) 225-5099
Intake and Evaluation team: (229) 225-5099

Baldwin County, Baker County, Bibb County, Calhoun County, Chattahoochee County, Clay County, Colquitt County, Crawford County, Crisp County, Decatur County, Dooly County, Dougherty County, Early County, Harris County, Houston County, Grady County, Jones County, Lee County, Macon County, Marion County, Miller County, Muscogee County, Mitchell County, Monroe County, Peach County, Pulaski County, Putnam County, Quitman County, Randolph County, Schley County, Seminole County, Stewart County, Sumter County, Talbot County, Taylor County, Terrell County, Twiggs County, Thomas County, Webster County, Wilkinson County, Worth County

Region 5

Regional Office: (912) 303-1670
Intake and Evaluation team: 1-(800) 348-3503, (912)-303-1649

Appling County, Atkinson County, Bacon County, Ben Hill County, Berrien County, Bleckley County, Brantley County, Brooks County, Bryan County, Bulloch County, Camden County, Candler County, Charlton County, Chatham County, Clinch County, Coffee County, Cook County, Dodge County, Echols County, Effingham County, Emanuel County, Evans County, Glynn County, Irwin County, Jeff Davis County, Johnson County, Lanier County, Laurens County, Liberty County, Long County, Lowndes County, McIntosh County, Montgomery County, Pierce County, Tattnall County, Telfair County, Tift County, Toombs County, Treutlen County, Turner County, Wheeler County, Wilcox County, Ware County, Wayne County

Disability Resource Group (formerly Georgia ADA Exchange)
(770) 451-2340
<http://www.gaada.info>

National Down Syndrome Society
1-(800) 221-4602
<http://www.ndss.org>

National Down Syndrome Congress
1-(800) 232-6372, (770) 604-9500
<http://ndsccenter.org>

United States Department of Justice
ADA Information Line
1-(800) 514-0301
<http://www.usdoj.gov/crt/ada>

National Association of Councils on Developmental Disabilities
(703) 739-4400
<http://capwiz.com/nacdd/home>

United States Department of Health and Human Services
Office for Civil Rights
1-(800) 368-1019, (404) 562-7886
<http://www.hhs.gov/ocr>

Legal Assistance (Referrals or direct representation)

Atlanta Legal Aid Society
(404) 524-5811 (Atlanta-downtown)
<http://www.atlantalegalaid.org>
**Cobb County, (770) 528-2565
**DeKalb County – Decatur (404) 377-0701
**Gwinnett County (678) 376-4545
**South Metro Atlanta (404) 366-0586
**AIDS/Cancer and ALS Legal Initiative
** (404) 614-3969
**Grandparent/Caregiver Project
** (404) 614-3911
**Georgia Seniors Hotline 1-(888) 257-9519
**Hispanic Outreach Law Project
** (404) 377-5381

American Civil Liberties Union
404-523-5398
<http://www.aclu.org>

State Bar of Georgia
Pro Bono Project
(404) 527-8762
<http://www.gabar.org>

Atlanta Bar Association Lawyer (Atlanta-downtown)
Referral Service
(404) 521-0777
<http://aba.affiniscape.com/index.cfm>

Georgia Legal Services Program
Administrative office (404) 206-5175, 1-(800) 498-9469
<http://www.glsp.org>

***Albany Office (229) 430-4261, 1-(800) 735-4271
***Augusta Office (706) 721-2327, 1-(800) 248-6697
***Columbus Office (706) 649-7493, 1-(800) 533-3140
***Dalton Office (706) 272-2924, 1-(888) 408-1004
***Gainesville Office (770) 535-5717, 1-(800) 745-5717
***Macon Office (478) 751-6261, 1-(800) 560-2855
***Piedmont Office (404) 894-7707, 1-(800) 822-5391
***Savannah Office (912) 651-2180, 1-(888) 220-8399
***Valdosta Office (229) 333-5232, 1-(800) 546-5232
***Waycross Office (912) 264-7301, 1-(877) 808-0553

Legal Aid-Ga.
<http://www.legalaid-ga.org>

Georgia Public Defender Standards Council, Office of the Mental
Health Advocate
(404) 232-8900
<http://www.gpdsc.org/omha-main.htm>

Cobb County Bar Association Lawyer Referral Service

(770) 424-7149
<http://www.cobbbar.org/referrals.htm>

Georgia Justice Project
(404) 827-0027
<http://www.gjp.org>

DeKalb Bar Association Lawyer Referral Service
(404) 373-2580
<http://www.dekalbbar.org/search>

Attorney Search Network
1-(800) 215-1644
<http://www.georgialawyerreferral.com>

Southern Center for Human Rights
(404) 688-1202
<http://www.schr.org>

Atlanta Volunteer Lawyers Foundation
(404) 521-0790
<http://www.avlf.org/>

Georgia Law Center for Homeless Persons
(404) 681-0680
<http://www.galawcenter.org>

FindLaw for the Public
<http://lawyers.findlaw.com/lawyer/state/Georgia>

Georgia Court Appointed Special Advocates, Inc.
(404) 874-2888, 1-(800) 251-4012
<http://gacasa.org>

Mitigation South
(404) 636-5947, (404) 797-1078



GLOSSARY OF COMMON MENTAL HEALTH TERMS

ADD – see attention deficit disorder. [Note: the diagnostic term ADD is no longer used in the DSM-IV-TR. The diagnostic category, term, and acronym “attention deficit/hyperactivity disorder (ADHD)” are now being used for persons diagnosed with this disorder].

ADHD – see attention deficit/hyperactivity disorder.

Affect – a person’s immediate emotional state or mood that can be recognized by others.

Affective disorder – a mental disorder characterized by disturbances of mood. Depression, mania, “manic-depression,” and bipolar disorders in which the individual experiences both extremes of mood are examples. Also called mood disorder.

Antisocial personality – a type of personality disorder marked by impulsivity, inability to abide by the customs and laws of society, and lack of anxiety, remorse, or guilt regarding behavior.

Anxiety – a state of apprehension, tension, and worry about future danger or misfortune. A feeling of fear and foreboding. It can result from a tension caused by conflicting ideas or motivations. Anxiety manifests through symptoms such as palpitations, dizziness, hyperventilation, and faintness.

Anxiety disorders – a group of mental disorders characterized by intense anxiety or by maladaptive behavior designed to relieve anxiety. Includes generalized anxiety and panic disorders, phobic and obsessive-compulsive disorders, social anxiety, and post-traumatic stress disorder.

Antidepressants – medications used to elevate the mood of depressed individuals and also to relieve symptoms of anxiety conditions.

Antipsychotic medications – medications that reduce psychotic symptoms; used frequently in the treatment of schizophrenia.

Attention Deficit Disorder (ADD) – This older term from the DSM-III-R was known as Attention Deficit Disorder with or without hyperactivity. Now, however, it is no longer used as a diagnostic category in the DSM-IV-TR. Current terminology and usage invokes the term attention deficit/hyperactivity disorder (ADHD). It is a type of disorder marked by inattentiveness, overactivity, or both.

Attention Deficit/Hyperactivity Disorder (ADHD) – a disorder, usually of children but also present in adults, characterized by a persistent pattern of inattention and/or hyperactivity and impulsivity that is more frequent and severe than is typically found in individuals of a comparable level of development. Symptoms might include impatience, fidgetiness, excessive talking, inability to focus or pay attention, and distractibility.

Atypical antipsychotics – a new group of medications used primarily to treat schizophrenia with broader effectiveness and few side effects. Also called new generation antipsychotics.

Auditory hallucinations – voices or noises that are experienced by an individual that are not experienced by others.

Autism – a mental disorder, first evident during early childhood, in which the child shows significant deficits in communication, social interaction, and bonding and play activities, and engages in repetitive behaviors and self-damaging acts.

Behavior therapy – a method of therapy based on learning principles. It uses techniques such as reinforcement and shaping to modify behavior.

Behavioral healthcare – a global term used to describe services provided for the treatment of mental illness, substance abuse, and other behavioral disorders.

Benzodiazepines – a class of anti-anxiety medications that have addiction potential in some people.

Bipolar disorder – a mood disorder in which people experience episodes of depression and mania (exaggerated excitement) or of mania alone. Typically the individual alternates between the two extremes, often with periods of normal mood in between. Also called manic-depression.

Borderline personality disorder – a mental disorder in which the individual has manifested unstable moods, relationships with others, and self-perceptions chronically since adolescence or childhood. Self-injury is frequent.

Clinical psychologist – a psychologist, usually with a Ph.D. or Psy.D. degree, trained in the diagnosis and treatment of emotional or behavioral problems and mental disorders.

Cognitive behavior therapy – a therapy approach that emphasizes the influence of a person's beliefs, thoughts, and self-statements on behavior. It combines behavior therapy methods with techniques designed to change the way the individual thinks about self and events.

Cognitive impairment – a diminution of a person's ability to reason, think, concentrate, remember, focus attention, and perform complex behaviors.

Compulsion – the behavioral component of an obsession. A repetitive action that a person feels driven to perform and is unable to resist; ritualistic behavior.

Conduct disorder – a childhood disorder characterized by a repetitive and persistent pattern of behavior that disregards the basic rights of others and major societal norms or rules.

DSM-IV-TR – the fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, text revision. This is a nationally accepted book that classifies mental disorders. It presents a psychiatric nomenclature designed for diagnosing different categories of and specific psychiatric disorders.

Decompensation – a gradual or sudden decline in a person's ability to function accompanied by the re-emergence of psychiatric symptoms.

Delusion – false beliefs characteristic of some forms of psychotic disorder. They often take the form of delusions of grandeur or delusions of persecution.

Dementia – a chronic organic mental illness that produces a global deterioration in cognitive abilities and that usually runs a deteriorating course.

Depression – an affective or mood disorder characterized by a profound and persistent sadness, dejection, decreased motivation and interest in life, negative thoughts (for example, feelings of helplessness, inadequacy, and low self-esteem) and such physical symptoms as sleep disturbances, loss of appetite, and fatigue and irritability.

Disruptive behavior disorder – a class of childhood disorders including conduct disorder, oppositional defiant behavior, and attention deficit/hyperactivity disorder.

Dissociative identity disorder – see multiple personality disorder.

Electroconvulsive therapy – a treatment for severe depression in which a mild electric current is applied to the brain, producing a seizure similar to an epileptic convulsion. Also known as electroshock therapy. It is most often used to treat severe, persistent depression.

Electroshock therapy – see electroconvulsive therapy.

Family therapy – psychotherapy with the family members as a group rather than treatment of the patient alone aimed at addressing family dysfunction and leading to improved family function.

Fetal alcohol syndrome – abnormal development of the fetus and infant caused by maternal alcohol consumption during pregnancy. Features of the syndrome may include retarded growth, small head circumference, a flat nasal bridge, a small mid-face, shortened eyelids, and mental retardation.

Generalized anxiety disorder – an anxiety disorder characterized by persistent tension and apprehension. May be accompanied by such physical symptoms as rapid heart rate, fatigue, disturbed sleep, and dizziness.

Group therapy – a group discussion or other group activity with a therapeutic purpose participated in by more than one client or patient at a time.

Hallucination – a sensory experience in the absence of appropriate external stimuli that is not shared by others; a misinterpretation of imaginary experiences as actual perceptions.

Hypomania – an affective disorder characterized by elation, overactivity, and insomnia.

Illusion – a misperception or misinterpretation of a real external stimulus so that what is perceived does not correspond to physical reality.

Impulse control disorders – a category of disorders characterized by a failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. A number of specific disorders, including substance abuse disorders, schizophrenia, attention deficit/hyperactivity disorder, and conduct disorder have impulse control features.

Learning disorders – learning problems that significantly interfere with academic achievement or activities of daily living involving reading, math, or writing. They are typically diagnosed from achievement on standardized tests.

Lithium carbonate – a compound based on the element lithium that has been successful in treating bipolar disorders.

MRI (magnetic resonance imaging) – a computer-based scanning procedure that generates a picture of a cross-section of the brain or body.

Malingering – feigning or significantly exaggerating symptoms for a conscious gain or purpose such as to get a change in conditions of confinement.

Mania – an affective disorder characterized by intense euphoria or irritability, exaggerated excitement, and loss of insight.

Manic-depressive disorder – A mood disorder in which people experience episodes of depression and mania (exaggerated excitement) or of mania alone. Typically the individual alternates between the two extremes, often with periods of normal mood in between. Also called bipolar disorder.

Mental illness – a generic term used to refer to a variety of mental disorders, including mood disorders, thought disorders, eating disorders, anxiety disorders, sleep disorders, psychotic disorders, substance abuse disorders, personality disorders, behavioral disorders, and others.

Mental retardation – a permanent condition usually developing before 18 years of age that is characterized by significantly subaverage intellectual function accompanied by significant limitations in adaptive functioning in other areas such as communication, self-care, home living, self-direction, social/interpersonal skills, work, leisure, and health.

Mood disorder – a mental disorder characterized by disturbances of mood. Depression, mania, and bipolar disorders, in which the individual experiences both extremes of mood, are examples. Also called affective disorder.

Multiple personality disorder – the existence of two or more distinct identities or personalities within the same individual. Each identity has its own set of memories and characteristic behaviors. The identities are believed to develop as a way of protecting the individual from the effects of severe abuse or trauma. Also called dissociative identity disorder.

Neuroimaging – newly developed computerized techniques that can create visual images of a brain in action and indicate which regions of the brain show the most activity during a particular task. Two common neuroimaging techniques are positron emission tomography (PET) and magnetic resonance imaging (MRI).

Neurosis (pl. neuroses) – a mental disorder in which the individual is unable to cope with anxieties and conflicts and develops symptoms that he or she finds distressing, such as obsessions, compulsions, phobias, or anxiety attacks. This is no longer a diagnostic category of DSM-IV-TR.

Nervous breakdown – a non-technical term used by the lay public, usually referring to an episode of psychosis.

Neuroleptic drugs – a category of older medications used to treat psychoses. Many have been linked to neurological side effects.

New generation antipsychotics – see atypical antipsychotics.

Obsession – An unpleasant or nonsensical thought that intrudes into a person's mind, despite a degree of resistance by the person. Obsessions may be accompanied by compulsive behaviors. A persistent, unwelcome, intrusive thought.

Obsessive-compulsive disorder – an anxiety disorder involving recurrent unwelcome thoughts, irresistible urges to repeat stereotyped or ritualistic acts, or a combination of both of these.

Oppositional defiant disorder – a childhood disorder characterized by a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists over time.

Panic attack – a sudden onset of intense apprehension, fearfulness, or terror often associated with feelings of impending doom, imminent heart attack, or other fears that often drive someone to seek medical care.

Panic disorder – an anxiety disorder in which the individual has sudden and inexplicable episodes of terror and feelings of impending doom accompanied by physiological symptoms of fear (such as heart palpitations, shortness of breath, muscle tremors, faintness).

Paranoia – a pervasive distrust and suspiciousness of others; suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

Paranoid schizophrenia – a schizophrenic reaction in which the patient has delusions of persecution.

Personality disorder – an enduring pattern of perceiving, relating to, and thinking about the environment and oneself that begins by early adulthood, is exhibited in a wide range of personal and social contexts, and leads to impairment or distress; it is a constellation of traits that tend to be socially maladaptive.

Phobia – excessive fear of a specific object, activity, or situation that results in a compelling desire to avoid it.

Phobic disorder – an anxiety disorder in which phobias are severe or pervasive enough to interfere seriously with the individual's daily life.

Positron emission tomography (PET scan) – a newly developed technique that can create visual images of a brain in action and indicate which regions of the brain show the most activity during a particular task.

Post-traumatic stress disorder – an anxiety disorder in which a stressful event that is outside the range of usual human experience, such as military combat or a natural disaster, induces symptoms such as a re-experiencing of the trauma and avoidance of stimuli associated with it, a feeling of estrangement, a tendency to be easily startled, nightmares, recurrent dreams, and disturbed sleep.

Psychiatrist – a medical doctor specializing in the treatment and prevention of mental disorders both mild and severe.

Psychoactive drugs – drugs that affect a person's behavior and thought processes, including non-prescription or "street" drugs.

Psychotropic drugs – prescribed medications that affect a person's behavior and thought processes.

Psychoanalysis – a method of intensive and in-depth treatment for mental disorders emphasizing the role of unconscious processes in personality development and unconscious beliefs, fears, and desires in motivation.

Psychologist – a person with a Masters degree, Ph.D., Ed.D., or Psy.D., and a license in psychology, the study of mental processes and behavior. Psychologists can specialize in counseling and clinical work with children and/or adults who have emotional and behavioral problems, testing, evaluation, and consultation to schools or industry, but cannot prescribe medications.

Psychopathic personality – a behavior pattern that is characterized by disregard for, and violation of, the rights of others and a failure to conform to social norms with respect to lawful behavior.

Psychosis (pl. psychoses) – a severe mental disorder in which thinking and emotion are so impaired that the person is seriously out of contact with reality.

Psychosomatic disorder – physical illness that has psychological causes.

Psychotherapy – treatment of personality maladjustment or mental disorders by interpersonal psychological means.

Psychotic behavior – behavior indicating gross impairment in reality contact as evidenced by delusions and/or hallucinations. It may result from damage to the brain or from a mental disorder such as schizophrenia or a bipolar disorder, or a metabolic disorder.

Repression – a defense mechanism in which an impulse or memory that is distressing or that might provoke feelings of guilt is excluded from conscious awareness.

Schizoaffective Disorder – a mental disorder in which a mood disturbance and the active symptoms of schizophrenia occur together.

Schizophrenia – a group of mental disorders characterized by major disturbances in thought, perception, emotion, and behavior. Thinking is illogical and usually includes delusional beliefs; distorted perceptions may take the form of hallucinations; emotions are flat or inappropriate. The individual withdraws from other people and from reality.

Shock therapy – see electroconvulsive therapy.

Social phobia – extreme insecurity in social situations accompanied by an exaggerated fear of embarrassing oneself.

Sociopathic personality – a behavior pattern that is characterized by disregard for, and violation of, the rights of others and a failure to conform to social norms with respect to lawful behavior.

Stress – a state of arousal that occurs when people encounter events that they perceive as endangering their physical or psychological well-being.

Stress reaction or stress response – reactions to events an individual perceives as endangering his or her well-being. These may include bodily changes as well as psychological reactions such as anxiety, anger and aggression, and apathy and depression.

Stressors – events that an individual perceives as endangering his or her physical or psychological well-being.

Tangential – a word used to describe thoughts or words that are only marginally related to the issue at hand.

Tardive dyskinesia – an involuntary movement disorder or muscular activity that sometimes develops as the result of taking strong antipsychotic medication over a period of time.

Thought disorder – a disorder where associations between ideas are lost or loosened but are not perceived as such by the person.

Tic disorders – childhood disorders characterized by sudden, rapid, recurrent, involuntary motor movements or vocalizations. An example is Tourette's syndrome.

Tourette syndrome – a childhood disorder characterized by multiple motor tics and one or more vocal tics that causes marked distress or significant impairment in social, academic, or other important areas of function.



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