

EVALUATING MENTAL RETARDATION FOR FORENSIC PURPOSES

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It is estimated that people with mental retardation comprise about 2 to 3 percent of the general population, yet they comprise 4 to 10 percent of the inmate population in state and federal prisons nationwide (Petersilia, 2000). However, statistics for this population are varied and difficult to compare due to differences in the ways in which mental retardation is identified. Data for the year 2002 suggest that, in Texas, when IQ alone was used, rough estimates were that 7 percent, or 8,758 individuals, of the institutional division of the prison system were persons with mental retardation, and 751 were in state jails comprising 5.1 percent of that population (Texas Department of Criminal Justice, 2002). This does not take into account those on specialized caseloads of probation officers in the community or those who may have been diverted to residential programs.

Those individuals with mental retardation who make up the small percentage that come into contact with the criminal justice system are predominately male and generally function within the range of mild mental retardation. Yet, people with mental retardation are not a homogenous group. They demonstrate tremendous variation in skills, abilities, and presentation. They may not have any overt appearance of disability, and their cognitive difficulties may not be detected until there is prolonged interaction with them. Consequently, they may not be identified by law enforcement, attorneys, or judges who, by and large, have little training in recognizing mental disabilities. In some cases, an individual with mental retardation may be tried and convicted with no one having an awareness that he or she functions within the range of mental retardation. In such situations, there may also be no awareness that the condition may affect the person's ability to consult with an

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attorney and understand the processes and actions taking place in the courtroom. Mental retardation may further be confused with mental illness (Conley, Luckasson, & Bouthilet, 1992).

In addition to lack of understanding of mental retardation on the part of law enforcement personnel, attorneys, and judges, there are other factors that may contribute to a high risk of unjust conviction of people with mental retardation. For one, people with mental retardation generally have limited communication skills and memory for events (Conley, Luckasson, & Bouthilet, 1992). They may not understand complex sentences and abstract concepts. Second, many people with mental retardation display impulsivity that may cause them to respond or act before thinking through their actions (Conley, Luckasson, & Bouthilet, 1992). Third, in an effort to acquiesce and please others, they may waive rights without understanding them (Everington & Fulero, 1999). They are easily coerced or “left holding the bag” by more capable companions. Some may be passive, preferring not to draw attention to themselves, while others may enjoy the attention they receive from police or others in the criminal justice system. Fourth, many individuals with mental retardation may want to be accepted by others so much that they attempt to hide their disability. Edger-ton (1967) called this the “cloak of competence,” which may often be successful around persons who have little experience with or understanding of mental retardation.

This is not to say that the presence of mental retardation means that the person should automatically be exempt from prosecution. There are individuals with mental retardation who are capable of planning a crime, conferring with an attorney, understanding charges and processes, and understanding right from wrong. Each person must be considered individually. However, to complicate matters, there are individuals who attempt to feign mental retardation in the belief that this will help them avoid or lessen the severity of punishment.

Since the Supreme Court decision on banning the execution of persons with mental retardation who commit capital offenses (Atkins v. Virginia, 2002), states have been struggling with how

this process will be operationalized. Texas is no exception. No legislation has yet been passed, and evaluators are advised to stay current about new laws in this area. However, some considerations are also offered and discussed regarding this topic.

This article focuses on assessment of mental retardation for Texas statutes on incompetency to stand trial (Texas Code of Crim. Proc., Art. 46B), the insanity defense (Texas Code Crim. Proc., Art. 46.03), juvenile fitness to proceed proceedings (Texas Fam. Code, Sec. 51.20 and Sec. 55.31), and juvenile lack of responsibility for conduct (Texas Fam. Code, Sec. 55.51).

KEY TERMS

Deviation IQ: an IQ score derived from a formula showing distance from the mean, or average, in terms of standard deviations.

Approximate Levels of Mental Retardation:

Level	IQ Range
Mild	55 to 70
Moderate	35 to 54
Severe	20 to 34
Profound	Below 20

Ratio IQ: Mental Age divided by Chronological Age multiplied by 100. Please note that most tests specify age 18 as the maximum Chronological Age.

Standard Deviation: a measure describing the variance, or distance, of a score from the mean, or average.

Standard Error of Measurement (SEM): a statistical term used in psychometrics, which reflects how reliably a test may measure an examinee's score if the test were independently repeated a number of times. Obtained scores would be expected to cluster around the individual's true score such that an obtained score may actually represent a range of scores. Some evaluators choose to include a 95 percent confidence level that covers the range of

scores plus and minus one SEM. Some definitions of mental retardation also require that one or more scores on a standardized measure of adaptive behavior fall two or more standard deviations below the age group mean.

DEFINITION OF MENTAL RETARDATION

Mental retardation has been defined by a variety of authoritative sources. All essentially address the need to include three elements: subaverage intellectual functioning, limitations in adaptive behavior, and onset during the developmental period. The three definitions most relevant to Texas evaluators are discussed below.

AAMR 2002 Definition

The American Association on Mental Retardation (AAMR) is generally the leader in defining mental retardation in the United States. However, their 1992 definition (Luckasson, R., Coulter, D.A., Polloway, E.A., Reiss, S., Schalock, R.L., Snell, M.E., Spitalnik, D.M., & Stark, J.A., 1992) was not widely accepted. That definition recommended classifying individuals by intensity of supports, substituted assessment of 10 adaptive skill areas for global adaptive functioning and employed a multidimensional assessment approach. AAMR revised the definition in 2002 as follows:

“Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. The disability originates before age 18.”

Intelligence is defined as “a general mental ability. It includes reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, learning quickly, and learning from experience.”

Adaptive behavior is defined as “the collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives.”

There are also five assumptions noted that are said to be essential to this definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age, peers, and culture.
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.
3. Within an individual, limitations often coexist with strengths.
4. An important purpose of describing limitations is to develop 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.

Thus, this definition is multidimensional and refers to a particular state of functioning that begins early in life and which can be positively affected by individual supports. With regard to the measurement of intellectual functioning, this definition provides a recognition that intelligence is best conceptualized as a general factor that includes the ability to reason, solve problems, think abstractly, plan, and learn from experience. The authors of the AAMR Manual believe that intelligence is best measured through use of a standardized test and that significant limitations in intellectual functioning are indicated by a score that is two or more standard deviations from the age group mean for the test. They further promote consideration of the actual standard error of measurement for the specific instrument. It should be noted that none of the tests reviewed have a standard error of measurement that would allow for an IQ of 75 to be used in the determination of mental retardation.

According to the 2002 AAMR definition, adaptive behavior is the “collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives” (p.73). Use of standardized instruments that are normed using people with and without disabilities is promoted. The authors use a cutoff of two or more standard deviations below the mean for establishing significant limitations in adaptive behavior. This can apply to one of the three types of adaptive behavior (e.g., conceptual, social, or practical) or to an overall score that includes all three. Problem, or maladaptive, behavior is not included in the definition, though such behavior can interfere with an individual’s daily activities.

This definition is reflective of current philosophy within the field of mental retardation.

DSM-IV-TR

The Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000) defines mental retardation using the criteria listed below:

- A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test.
- B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person’s effectiveness in meeting the standards expected of his or her age or his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.
- C. The onset is before age 18 years.

The DSM-IV-TR indicates that there is a measurement error of approximately 5 points in assessing IQ that allows for mental retardation to be diagnosed with an IQ of up to 75. It also acknowledges that an individual with an IQ of less than 70 who does

not display deficits in adaptive behavior could not be classified as having mental retardation.

Texas Health and Safety Code/Persons with Mental Retardation Act

In Texas, the definition contained within the Persons with Mental Retardation Act (PMRA) (Texas Health & Safety Code, 1991, as amended in 1993), is the one used in most laws referring to mental retardation. This definition is the one promoted by the American Association on Mental Retardation (AAMR) in 1973 when the act was first adopted. As defined in the PMRA, mental retardation means subaverage general intellectual functioning occurring concurrently with deficits in adaptive behavior and originating during the developmental period. Subaverage general intellectual functioning means an IQ score two or more standard deviations below the mean for the test used. For those tests with a standard deviation of fifteen, this is below an IQ of 70 (this would be an IQ of 68 or lower for those tests with a standard deviation of 16). Adaptive behavior refers to the degree to which a person meets the criteria for independence expected of his or her age and cultural group. Developmental period means the period of time between birth and the eighteenth birthday. All three elements must be present for the diagnosis to be valid under this law.

The PMRA does not discuss using a standardized measure of adaptive behavior. However, rules of the former Texas Department of Mental Health and Mental Retardation (TDMHMR), now known as the Department of Aging and Disability Services (DADS), do speak to this when delineating accepted practices for determining diagnostic eligibility for services (Texas Admin. Code, 2000), and on requirements for admission or commitment to a state mental retardation facility (Texas Admin. Code, 2001). It should be noted that, for admission or commitment to a state mental retardation facility, the state of Texas requires that the person have intellectual functioning within the range of severe or profound mental retardation, a service level of 1, 2, 3 or 4 on the Inventory of Client and Agency Planning (ICAP) (Bruininks, Hill, Weatherman, & Woodcock, 1986), a service level of 5 or 6 on the

ICAP and evidence of extreme behavioral or medical need, or that the individual meet other criteria yet to be set by DADS.

INTELLECTUAL TESTING

The personal characteristics of the individual to be evaluated guide the selection of the test used. Both the individual's and the instrument's strengths and weaknesses should be given careful consideration. The choice of the test used should be based on consideration of factors such as verbal abilities, motor skills, physical or sensory limitations, attention span, and primary language of the individual (Texas Department of Mental Health & Mental Retardation, Best Practice Guidelines, 2000).

Since evaluators strive to administer intellectual and other tests in settings that are the most conducive to obtaining the most reliable and valid results, this may pose challenges when working with individuals who are incarcerated. Talking with authorities ahead of time and explaining the need for standardized testing conditions may be helpful in securing a suitable setting. Emotions or events may influence an individual's attention and level of participation in the evaluation. When any of these are present, assessments may need to be rescheduled or such limitations must, at least, be noted in the report.

Comprehensive Instruments

Whenever possible, intellectual testing is best conducted utilizing a comprehensive, standardized measure of intellectual functioning. A full-length test has several advantages over a short or abbreviated form, though there may be exceptions as noted later in this section. The Standards for Educational and Psychological Testing (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999) note that it is important to administer tests to the examinee as the manual specifies including setting and instructions so that the test results are not invalidated. Whenever the examinee's needs justify deviation from standardized procedures, this is to be noted in the report along with a statement about the possible effect on the validity of the results. Likewise, whenever a full test

is not used, or when subtests are omitted, the evaluator is to note this along with the reasons for the change in the standard method of administration. Of course, comprehensive testing should be conducted in the primary language of the individual. When this is not possible, such as when the individual speaks an unusual language or dialect for which no evaluator can be located, trained interpreters might be used to assist in introducing a nonverbal test and collecting other information. Trained interpreters are aware of the requirements of tests and do not provide additional instruction or assistance that would further affect validity. The reader is referred to the section on cultural competence in the ethics article for further discussion of this topic.

Currently, the most widely used instruments for measuring overall intellectual functioning are the Wechsler scales and the Stanford-Binet Intelligence Scales. The Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) (Wechsler, 2003) and the Stanford-Binet Intelligence Scales, Fifth Edition (SB5) (Roid, 2003) have recently been redesigned. The Stanford-Binet changed its standard deviation from 16 points to 15 points, the same as the current Wechsler scales. These tests offer information on verbal and performance, or non-verbal, skills, as well as domains associated with contemporary models of intelligence. Their reliability in terms of internal consistency reliability coefficients in standardization samples has been extremely strong. Yet, the manuals for these scales caution about their use for individuals who may score in extreme ranges, high or low. Sattler (1988) indicated that both instruments are useful in assessing mental retardation, though he also cautioned about their use with persons whose functioning may be at the extreme ranges. Lack of inclusion of persons in these ranges in the normative groups makes the results subject to measurement error. These instruments are best employed for use with persons whose scores fall within the moderate to mild levels of mental retardation, or two to three standard deviations from the mean (AAMR, 2002). This range includes those individuals who most often come in contact with the criminal justice system. For a discussion of measures of intellectual functioning, the reader is referred to the Appendix on Intellectual Measures following this article.

Use of Other Instruments

Depending upon the examinee's skills and disabilities, there may be times when procedures or tests other than the comprehensive tests discussed above are needed. A nonverbal test or portion of a full test may be required for a person who has a hearing impairment, limited vocabulary or verbal skills, or when other types of tests may appear inappropriate or biased. In these instances, it may be useful to administer the performance section of a Wechsler Scale or to use a nonverbal measure such as one discussed in the Appendix on Intellectual Measures. The verbal portion of a Wechsler scale may likewise be used for those individuals with poor motor skills. Again, examiners should indicate the reason for departure from standard procedures. All of these measures may be shorter in administration time than the more comprehensive instruments.

While a full-length test is preferable, there are situations in which an abbreviated or nonverbal instrument, such as those discussed above, may be acceptable or may even be the most appropriate measure of intellectual functioning. For example, if an adult has a lengthy, consistent, documented history of scoring within the range of mental retardation on comprehensive tests of intelligence, repeating the same test is not likely to render new information. Repeating the same test over a two-year period may result in "practice effects" in which the individual memorizes or remembers items, thus invalidating the results. A brief test may serve to confirm the diagnosis. However, when there have been several years since the last evaluation, it would appear appropriate to administer the comprehensive test again. Also, some individuals have poor ability to attend to task for a long period of time. These individuals may become so frustrated that they refuse to continue to participate or there may be no reasonable way to break up testing into smaller sessions. There may be others yet who do not appear to understand instructions for the more comprehensive tests or who obtain zero raw scores on several subtests rendering their full scale IQ score to be of questionable validity. An examiner should note attempts to administer a comprehensive instrument then list the

reasons for choosing to use an abbreviated or nonverbal instrument.

Although they are not usually encountered in forensic situations, there are individuals who appear to function at the lower end of the range of mental retardation and for whom none of the above tests appear appropriate. For these individuals who cannot participate in traditional individual testing, estimation of intellectual functioning may be based on scores on other types of tests. The Vineland Adaptive Behavior Scale (VABS) (Sparrow, Balla, & Cicchetti, 1984) and the Vineland Adaptive Behavior Scale, Second Edition (VABS-II) (Sparrow, Cicchetti, & Balla, 2005) yield a Composite Score that has a high correlation with IQ for individuals of all ages. The Developmental Profile II (DPII) (Alpern, Boll, & Shearer, 1986) provides a ratio IQ estimate for children and young adolescents. These IQ estimates are useful when a specific score is required, such as when an individual enrolls in a Medicaid program or is admitted to a state school. When examiners use these estimates, they generally document that individual testing was attempted and the individual was unable to adequately participate.

ADAPTIVE BEHAVIOR ASSESSMENT

Assessment of adaptive behavior for diagnostic purposes is best accomplished through use of a standardized instrument. Such instruments should be psychometrically sound, address conceptual, social and practical skills, and be normed on groups that include people with and without mental retardation (AAMR, 2002). Most adaptive behavior instruments measure skills typically displayed by the individual in his or her environment. The individual's culture must also be considered as a factor that may influence expression of adaptive behavior. Assessment generally relies upon information gathered from a third party who knows the individual well. See the Appendix on Adaptive Behavior Measures following this article for a list of adaptive behavior instruments.

The 2002 AAMR manual on the definition of mental retardation notes that a person should have a score of two or more standard deviations below the mean on at least one domain or on the

total score of an instrument that measures all three domains (conceptual, social and practical skills). Other definitions are not as specific, though, as noted earlier, rules for DADS programs contain requirements for adaptive behavior assessment through use of a standardized measure.

There are evaluators who assess adaptive behavior without a formal measure. They use straightforward questions about adaptive functioning. Areas of inquiry may include whether the person has ever had a checking account, owned a car, had a driver's license, signed a lease, obtained a loan, cooked a complex meal, bought clothes that coordinated and fit well, repaired an appliance, read a novel, or taken college classes.

Problems in Adaptive Behavior Assessment for Persons in the Criminal Justice System

Use of standardized measures of adaptive behavior is often criticized as inappropriate for use with forensic populations. It is said that individuals within this population may differ from normative samples in terms of cultural group and behaviors that are acceptable within that cultural group. Also, there may be tremendous problems in locating informants that can provide information that reflects typical behavior for the individual. The Street Survival Skills Questionnaire (SSSQ) (Linkenhoker & McCarron, 1993) or the Adaptive Behavior Assessment System (ABAS) (Harrison & Oakland, 2000) could be useful in the measurement of adaptive behavior for this population since they do not solely rely on an informant interview. Evaluators should be aware that, within the mental retardation field, in order to ensure that adaptive behavior assessment is consistent with accepted practice and that there is consistency in the application and interpretation of constructs, use of such measures may be needed.

As mentioned earlier, there are evaluators who choose not to use standardized measures of adaptive behavior. For this population, they might ask who writes the individual's requests for personal items, letters to home and how legible, as well as new pleas to the court.

Suggested Methods to Assess Adaptive Behavior When Limitations are Present

Adaptive behavior assessment is strengthened through use of multiple informants and approaches including observation of the individual in various settings and activities. This may require the evaluator to do some research and find informants from different settings. Evaluators must take into account the informant's relationship to the individual assessed and the potential gains for the informant. This is particularly important when the informant may not have the opportunity to observe the individual in his or her typical environments. Using several different informants and multiple methods of assessment may help address these issues. Clinical judgment, based on experience and expertise, should be relied upon to assist in these situations. Clinical judgment can be thought of as "a special type of judgment rooted in a high level of clinical experience...it should be viewed as a tool of clinicians with training and expertise in mental retardation and ongoing experiences with – and observations of – people with mental retardation and their families (AAMR, 2002, p. 95)."

ESTABLISHING DEVELOPMENTAL HISTORY OF MENTAL RETARDATION

Establishing that intellectual and adaptive behavior limitations were present during the developmental period can be the most challenging aspect of the evaluation process. However, it is only through finding these historic links that one can separate those who truly meet the full criteria for a diagnosis of mental retardation from individuals who may have suffered brain injury or deterioration of functioning in adulthood. The evaluator may often need to become a detective and spend considerable time requesting information or interviewing persons from the individual's past.

School Records

Records of assessments completed by school districts offer reliable forms of proof of the presence of intellectual and adaptive behavior limitations during the developmental period. Other records from schools, such as reports from Admissions, Review and Dismissal (ARD) Committees that indicate that the individual was

eligible for special education services as a student with mental retardation are also excellent resources. However, it is often important to review the basis for special education classification carefully. Sometimes, public schools may fail to classify students as having mental retardation when tests are used that may artificially inflate scores or when students obtain a full scale IQ within the range of mental retardation but have a verbal or performance score above that range.

Assessments Done Prior to the Age of Eighteen

In addition to school assessments, other assessments completed by agencies before the individual was eighteen years old that include measures of intellectual functioning and adaptive behavior should be requested. Community mental health and mental retardation centers and state hospitals or state schools may have performed assessments, sometimes called Determinations of Mental Retardation (DMRs) or, in the past, Comprehensive Diagnoses and Evaluations (D&Es) in Texas, to determine the individual's eligibility for services. Also, if the individual applied for governmental benefits such as Medicaid or Supplemental Security Insurance (SSI), there should be documentation of information used to determine eligibility for these services, including intellectual testing. Individuals who have been detained as a juvenile may have been evaluated for the courts or probation departments. Other sources may include records from the Department of Protective and Regulatory Services (DPRS), now known as the Department of Family and Protective Services (DFPS), if the individual received services with that agency.

Interviews with Family Members and Others

It is important to gather information concerning pregnancy, birth, and early development from one or more family members or other persons with this knowledge. There may be medical records that contain some mention of intellectual functioning as well as information about physical traits and characteristics that are often associated with mental retardation.

Reports from family members and others that the individual was diagnosed with mental retardation as a child are generally accepted only after other methods have failed to provide documented

information. Efforts should be made to obtain as much supportive documentation as possible. Clinical judgment may need to be used when earlier information is lacking or incomplete (AAMR, 2002). However, when the individual to be assessed is an older adult with a history of other complicating factors, such as mental illness, trauma, or substance abuse, it may not be possible to determine that intellectual and adaptive behavior limitations were present during the developmental period. In these situations, the diagnosis of mental retardation should be based on available information and clinical experience, though quite often the individual may not be determined to have mental retardation.

ISSUES RELATED TO MALINGERING

It is not difficult for a person to score within the range of mental retardation on an intellectual measure. By simply refusing to respond, saying, "I don't know" on a number of items or responding slowly on timed items, the person can obtain a low IQ score. In addition to intentional false responding, depression and motivation can suppress IQ scores. Being arrested or incarcerated certainly cannot be discounted as sources of stress affecting mood and motivation. There are no validity indicators built into intelligence tests as there are in some major personality inventories. Likewise, adaptive behavior measurement can be complicated by the fact that an individual is incarcerated and must conform to requirements and routines, thus inflating scores. Or, an informant may exaggerate adaptive behavior limitations. Each may provide an inaccurate picture of the person's current functioning. However, since "origination during the developmental period" is also a requirement in all definitions and diagnostic criteria for mental retardation, there is a level of protection against such faking, but this requires careful investigation. Reliance on historically available IQ and adaptive functional skill assessments and indicators is the most reliable source of such information.

One clue that a person may be faking on an intellectual measure is when the person's adaptive behavior is vastly different than would be expected given the IQ score. It is difficult to rationalize how an individual can balance a checkbook, drive a vehicle,

and read novels, yet score within the high moderate to low mild range of mental retardation. Likewise, if the only time a person is evaluated for the presence of mental retardation is when he or she is in trouble with the law, what can emerge is a skewed perspective of his or her true abilities. For example, Johnny Paul Penry's IQ scores have ranged from the 40's to the 70's, all done while he was incarcerated.

The reader is referred to the article on malingering for discussion of instruments and techniques to assess cognitive malingering.

ESTABLISHING RELATIONSHIPS BETWEEN MENTAL RETARDATION AND PSYCHOLEGAL QUESTIONS

To find an individual incompetent to stand trial, insane, unfit to proceed, or lacking responsibility for conduct, Texas law basically requires that there be a connection to mental illness or mental retardation. It is important that the examiner explain in what way the mental disorder affects the specific area in question.

It should be noted that the likelihood of being found incompetent to stand trial increases significantly with the severity of the retardation (Petrella, 1992). When evaluating a person with mental retardation, evaluators must recognize the differences between diagnostic criteria and psycholegal criteria. Having a diagnosis of mental retardation does not automatically mean that a person lacks the ability to consult with an attorney or to have a factual and rational understanding of the proceedings, as is required for a finding of incompetent to stand trial for adults or unfit to proceed in juvenile cases. However, because of mental retardation, the person may, for example, lack sufficient vocabulary or ability to recall and describe events to his or her attorney or to understand the proceedings in court. Or, he or she may not be able to understand time concepts or put events together in chronological order. Both of these situations help explain why the person does not meet the psycholegal criteria. According to Bonnie (1992), when a defendant has a diagnosis of mental retardation, the ability to recall and describe relevant events, including state of mind, should be given

the most attention. In addition, focusing on such aspects helps the evaluator formulate recommendations for treatment of the individual and determination of restorability.

Likewise, evaluations to address the insanity defense or lack of responsibility for conduct should address what aspects of the individual's mental retardation affect the person's ability to know that his or her conduct was wrong. Juvenile Lack of Responsibility for Conduct under Texas Law also includes inability to conform behavior to the law. In this case, one example may be that the individual, because of mental retardation, lacks the ability to delay gratification such that this might meet the juvenile criteria. Satisfying the standard of lacking the ability to know that one's behavior is wrong is a very high standard that may not be easily met. Most instances of this involve a person who has a psychotic thought process. Relatively few offenders with mental retardation are unaware of the wrongfulness of their acts (Fitch, 1992). For mental retardation to be seen as affecting the ability to know right from wrong, it would seem to require a much lower level of intellectual functioning than is typical of persons with mental retardation who become involved in the criminal justice system.

Instruments and Techniques Used to Assess Trial Competence

Consideration should be given to all information available to assess trial competence. Historical information can provide a contrast to current observations. School records and records of past services can also provide this contrast. Interviews with others who know the individual's behavior may further assist in the assessment. In some situations, it may be helpful to assess an individual's reading level to determine the presence of problems with listening and understanding.

While there is no requirement to use an instrument as part of the assessment for trial competence or juvenile fitness to proceed, using such instruments allows for a more structured assessment and can provide information about how an individual's knowledge compares to a normative sample. The Competency Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR) (Everington, C.T., & Luckasson, R., 1992) is an

orally administered multiple-choice format tool that has three sections. The first section assesses an individual's knowledge of basic legal concepts, including legal terms and roles of persons in the court proceedings. The second section tests the individual's skills to assist the defense. The third section requires the individual to answer questions specific to his or her particular alleged offense to determine the level of understanding of case events. The normative sample included adults with and without mental retardation. Despite the fact that there are no current norms for juveniles, the CAST-MR is frequently used to assist in Fitness to Proceed assessments as well since it provides a structured method for assessing the skills needed by juvenile defendants.

There are currently no other instruments specifically designed for defendants with mental retardation. As new instruments to assess this area become available, evaluators should examine them carefully to determine if there were persons with mental retardation in the norm groups and to assess the appropriateness of the questions for the individuals to be assessed. In general, questions should be brief and to the point. They should also be open-ended or provide a few multiple-choice options. Vocabulary, other than legal terms, should be uncomplicated.

Mental Age, Developmental Issues, and Culpability

Mental age scores in forensic situations should be used carefully. It may be easy for an evaluator to explain to the court that a person solves problems like the average ten-year-old. However, mental age scores are often misinterpreted. An adult with a mental age score of ten years does not have "the mind of a child." Rather, the person's score on the test is at the same level of the average ten-year-old in the normative sample. The adult differs from the child in that he or she has had years of experience in the world and physical maturation that cannot be equated with the experience of a child.

The Texas Penal Code, Chapter 6, discusses culpability and culpable mental states. It classifies culpable mental states according to relative degrees, from highest to lowest, as follows: intentional, knowing, reckless and criminal negligence.

For years, there has been debate as to whether a defendant who has mental retardation should be held to the same standard of responsibility, or culpability, as those who do not. The mental infancy of adult “idiots” was used in early English cases as a reason for lack of responsibility for crimes (Fitch, 1992). This reasoning held that, since children under the age of fourteen were seen as incapable of crime, those with the same level of intellectual functioning should be regarded in the same way. However, American courts have consistently rejected extending laws protecting juveniles to adult defendants with low mental functioning. Fitch (1992) notes that such a system may not be desirable since many persons with mild or moderate mental retardation often do have sufficient ability to form intent and to distinguish right from wrong such that they may deserve a level of blame and punishment. He further notes that there may be therapeutic value in having people with mental retardation face natural consequences of their behavior and that relegating persons with mental retardation, as a group, to the status of children sets back the normalization movement for the population. Nevertheless, the use of “problem behavior” or criminal behavior as an indicator of the presence of or lack of impairment in adaptive behavior would appear inappropriate since both appear conceptually different and there is a low correlation between the two (AAMR, 2002).

Death Penalty

In June 2002, the United States Supreme Court held that executing criminals with mental retardation violated the Eighth Amendment prohibition of cruel and unusual punishment (*Atkins v. Virginia*, 2002). The Court concluded that such punishment was (a) excessive, and therefore prohibited, as judged by currently prevailing standards; (b) that there was persuasiveness in the fact that a significant number of states had concluded that the death penalty was unsuitable for a criminal with mental retardation indicating that society views such offenders as categorically less culpable than the average criminal; and (c) that the death penalty for criminals with mental retardation did not measurably advance the deterrent retributive purposes of the death penalty. They continued by saying that such offenders posed a special risk of being wrongfully

executed due to the likelihood of unwittingly confessing to crimes they did not commit, having poor ability to assist counsel, the fact that they may be poor witnesses and that their demeanor may create an impression that they lack remorse.

The opinion of the Court provided little guidance on the definition of mental retardation, other than that it includes subaverage intellectual functioning, significant limitations in adaptive skills and manifestation before age 18. There is no further specification or definition of terms, though footnotes do make mention of the 1992 AAMR definition, the DSM-IV definition and later an upper limit of a 70 to 75 IQ. This leaves states freedom to adopt their own wording. However, according to Ellis (2003), states cannot adopt a definition that encompasses a smaller group than what the Court referred to as all defendants with mental retardation about whom there is a national consensus, and they cannot fail to protect any individuals who have mental retardation as defined and embodied in the national consensus.

Texas has not yet adopted a definition or process for operationalizing the Supreme Court decision. There needs to be careful consideration of which of the definitions described earlier would be best suited to the courts. Use of IQ level alone does not appear to be in line with the Court's tripartite definition, though the use of the Standard Error of Measurement (SEM) may be a point of debate. Clinical judgment by experienced diagnosticians may also need to be considered. Adaptive behavior limitations must further be included to show that the individual has a disability that affects everyday aspects of his or her life. Age of onset appears to be a particularly important requirement in capital cases to prevent including those who may attempt to feign mental retardation to avoid the death penalty. Malingering on tests may occur, but faking a history of mental retardation is not so easily done.

SUMMARY AND CONCLUSIONS

Assessment of mental retardation in forensic evaluations can pose many challenges. The evaluator must be aware of the requirements of not only the laws governing the specific question

from the courts, but the definition of mental retardation to be used and criteria for placement in programs serving this population. Mental retardation should be conceptualized as having a three-pronged definitional requirement to include subaverage intellectual functioning with concurrent limitations in adaptive behavior that originates before the age of 18. The specific diagnosis referenced in the law dictates much about how assessment should occur. Forensic evaluators may have to interview a number of informants to determine adaptive behavior functioning and may need to be detectives to find evidence of mental retardation during the developmental period. In addition, locating an appropriate setting to conduct an evaluation may prove challenging when the examinee is incarcerated.

Once the testing, interviews and record reviews are complete, the report must be written and, frequently, the forensic evaluator will provide testimony in court regarding the results and recommendations. The evaluator may often be placed in the position of educating attorneys, judges and others about mental retardation, the system of services for individuals with mental retardation and the laws that govern these services. Therefore, it is imperative that the evaluator be informed of the most current information and that the written report and testimony provide information in an unbiased manner.

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Received: March 2006

Accepted: June 2006

Suggested Citation:

Seay, O. J. (2006). Evaluating mental retardation for forensic purposes [Electronic Version]. *Applied Psychology in Criminal Justice*, 2(3), 52-81.

APPENDIX A

Intellectual Measures

Children's Tests

A. Cognitive Assessment System - designed for use with children between the ages of 5 and 17. It has a mean of 100 and a standard deviation of 15. The normative sample was selected to reflect the characteristics of the United States general population in terms of gender, race, region, educational classification and parents' educational level. However, it has been criticized for not identifying as many children with mental retardation as the WISC-III and identifying fewer African American than white children as having mental retardation.

Reference: American Association on Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: Author.

Source: Riverside Publishing
425 Spring Lake Drive
Itasca, IL 60143-2079

B. Kaufman Assessment Battery for Children (K-ABC) and Kaufman Assessment Battery for Children, Second Edition (KABC-II) – the K-ABC was designed to measure achievement and intellectual functioning for children between the ages of 2.5 and 12.5 years (Kaufman & Kaufman, 1984) and the KABC-II is for ages 3 through 18 (Kaufman & Kaufman, 2003). The Mental Processing Scale has a mean of 100 and standard deviation of 15, like the Wechsler scales. A stratified sample was used and included children with exceptional needs. Supplemental sociocultural norms are also included.

Reference: American Association on Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: Author.

Source: American Guidance Services (AGS)

Publishing
4201 Woodland Road Circle Pines,
Minnesota 55014-1796

C. Wechsler Intelligence Scale for Children – Third Edition (WISC-III) and Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV)

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

Adult Test

Wechsler Adult Intelligence Scale – Third Edition (WAIS-III)

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

Test for Multiple Age Levels

Stanford-Binet Intelligence Scale, Fourth Edition and Stanford-Binet Intelligence Scale, Fifth Edition

Source: Riverside Publishing
425 Spring Lake Drive
Itasca, IL 60143-2079

Nonverbal Tests

A. Comprehensive Test of Nonverbal Intelligence (CTONI) - developed for use with people between 6 to 90 years of age. It has a mean of 100 and a standard deviation of 15. Instructions can be spoken or pantomimed. It has excellent correlation with the WISC-III and test-retest reliability is high. However, there were few individuals with disabilities included in the norm group.

Reference: American Association on Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: Author.

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

B. Leiter International Performance Scale-Revised (Leiter-R) - designed for use with persons between 2 and 21 years old. It specifically purports to be designed to include the assessment of mental retardation and giftedness. It requires no oral instruction or oral response. It also has good reliability and correlates highly with the WISC-III and the first edition of the Leiter. According to some reports (AAMR, 2002), scores for individuals from some minorities may be higher on the Leiter-R than on the WISC-III.

Reference: American Association on Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: Author.

Source: Stoelting Co.
620 Wheat Lane
Wood Dale, IL 60191

C. The Universal Nonverbal Intelligence Test (UNIT) - designed for use with children and adolescents who may not have the verbal skills to participate in more comprehensive tests. It is also designed for individuals who may have color-vision difficulties. Special education students were included in the normative sample. Its reliability and concurrent validity are reported to be high.

Reference: American Association on Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: Author.

Source: Riverside Publishing
425 Spring Lake Drive
Itasca, IL 60143-2079

Brief and Screening Tests

A. Kaufman Brief Intelligence Test (K-BIT) - does not appear appropriate for use in forensic assessments. Tests such as this were designed to indicate when a more comprehensive assessment should be completed.

Source: Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025-1251

B. Kaufman Brief Intelligence Test, Second Edition (KBIT-2) – newest version of the measure. Indicates it must be administered in English, but provides some correct responses in Spanish for specific items.

Source: American Guidance Services (AGS)
Publishing
4201 Woodland Road
Circle Pines, MN 55014-1796

C. Slosson Intelligence Test (SIT) - a brief instrument that yields an estimate of intellectual functioning that is widely recognized as having a high correlation with other tests. It has a mean of 100 and a standard deviation of 16.

Reference: American Association on Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: Author.

Source: Slosson Educational Publications, Inc.
P.O. Box 544
East Aurora, NY 14052-0544

D. Test of Nonverbal Intelligence, 3rd Edition (TONI-3) – designed for use with individuals who may have language or learning disabilities, speech disorders, deafness, or who may not read or write English well. It may inflate scores for persons who are within the lower levels of functioning.

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

E. Wechsler Abbreviated Intelligence Scale (WASI) – designed to be used as a quick estimate of intellectual functioning for use in screening or quick reassessment of individuals who have had a comprehensive evaluation. It is not meant to replace more comprehensive measures of intelligence.

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

Spanish Language Tests

A. Escala de Inteligencia Wechsler Para Adultos (EIWA) – a Spanish adaptation of the WAIS. The test was normed in 1968 in Puerto Rico, and is not appropriate for individuals in the mainland of the United States.

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

B. Escala de Inteligencia Wechsler Para Ninos – Revisada de Puerto Rico (EIWN-R PR) – a Spanish adaptation of the WISC-R. It was normed in Puerto Rico and is described as appropriate for Puerto Rican children ages 6 years to 16.11 years.

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

C. Escala de Inteligencia Wechsler Para Ninos – Revisada (EIWN-R) – a Spanish adaptation of the WISC-R published as a research edition without norms.

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

APPENDIX B

Adaptive Behavior Measures

A. Vineland Adaptive Behavior Scales (VABS), and Vineland Adaptive Behavior Scales, Second Edition (VABS-II) – based on interview with an informant and direct observation; provides results such that standard deviation can be used.

Source: American Guidance Service (AGS)
Publishing
4201 Woodland Road
Circle Pines, MN 55014-1796

B. AAMR Adaptive Behavior Scale – Residential and Community: Second Edition (ABS-RC:2) – uses informant; domain raw scores convert to standard scores ($M = 10$, $SD = 3$) and percentiles. Factor raw scores are used to generate quotients ($M = 100$, $SD = 15$) and percentiles.

Source: Pro-Ed
8700 Shoal Creek Blvd.
Austin, TX 78757-6897

C. Scales of Independent Behavior-Revised (SIB-R) – administered as a structured interview or checklist.

Source: Riverside Publishing
425 Spring Lake Drive
Itasca, IL 60143-2079

D. Comprehensive Test of Adaptive Behavior-Revised (CTAB-R) – provides specific skill statements with criteria and testing procedures. The authors purport that this reduces ambiguity and uncertainty.

Source: Educational Achievement Systems
7115 NE Roselawn St.
Portland, OR 97218

E. Adaptive Behavior Assessment System – Second Edition (ABAS – Second Edition) – incorporates current AAMR guidelines for three general areas specified in their 2002 definition of mental retardation. Assesses ten specific skills areas and a General Adaptive Composite Score by respondent completed checklist or examiner observation.

Source: Harcourt Assessment
19500 Bulverde Rd.
San Antonio, TX 78259-3701

F. Street Survival Skills Questionnaire (SSSQ) – individually administered; converts raw scores to scaled scores. It was normed on individuals with developmental disabilities in a variety of settings with a range of IQ scores from 28 to 80 and a group of adolescents in prevocational programs with IQ scores ranging from 20 to 121, though tables of norms for adult neuropsychologically disabled and average adults are also included. The obtained score, the Street Survival Quotient (SSQ), has a mean of 100 and a standard deviation of 15.

Source : McCarron-Dial Systems, Inc.
P.O. Box 45628
Dallas, TX 75245

G. Inventory for Client and Agency Planning (ICAP) – short, standardized instrument that assesses adaptive and maladaptive behaviors; often used to determine eligibility for services, planning programs, evaluating programs, and determining funding.

Source: Riverside Publishing
425 Spring Lake Drive
Itasca, IL 60143-2079