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THE DSM-5 AND CRIMINAL DEFENSE: WHEN DOES A DIAGNOSIS MAKE A DIFFERENCE?

Nancy Haydt*

Abstract

In June 2013, the American Psychiatric Association published the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (“DSM-5”). The DSM-5 was intended to be an updated guidebook for the clinical diagnosis of mental disorders. It received mixed reviews from the mental health community.¹ The reception from the forensic mental health community is likewise varied. The evolution of conceptualizing mental illness, its origins and treatment efficacy, may weaken the authority of the DSM and further confuse its application in forensic situations.² This Article explores the possible effects of the DSM-5 in criminal cases.

I. INTRODUCTION

Like its predecessors, the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (“DSM-5”)³ diagnostic criteria is “primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning.”⁴ However, courts and attorneys widely use the DSM-5 as a primary reference in assessing the nature and forensic implications of mental disorders. The American Psychiatric Association warns: “[I]t is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians,

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¹ Thomas Insel, Director of the National Institute of Mental Health, described the DSM-5 as follows: “While DSM has been described as a ‘Bible’ for the field, it is, at best, a dictionary, creating a set of labels and defining each.” Thomas Insel, *Director’s Blog: Transforming Diagnosis*, NAT’L INST. MENTAL HEALTH (Apr. 29, 2013), <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>, archived at <http://perma.cc/TV9R-ZDCK>.

² *See id.* (“We need to begin collecting the genetic, imaging, physiologic, and cognitive data to see how all the data—not just the symptoms—cluster and how these clusters relate to treatment response. That is why NIMH will be re-orienting its research away from DSM categories.”).

³ AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed. 2013) [hereinafter AM. PSYCHIATRIC ASS’N, DSM-5].

⁴ *Id.* at 25.

public health professionals, and research investigators *rather than all of the technical needs of the courts and legal professionals.*⁵

Using the DSM-5 in forensic settings has both “risks and limitations.”⁶ “DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure.”⁷ There is therefore a high likelihood of mismatch between the information available for forensic analysis and the symptomology, which would be the basis for a clinical diagnosis. Diagnostic criteria and reports of defendants’ behaviors are also often misused or misrepresented in forensic applications.⁸ While it is clear that legal determinations involving mental disorders should be informed by clinical practice,⁹ there is no requirement that any jurisdiction adopt verbatim DSM-5 language, terminology, or diagnostic practices.¹⁰

In addition, the law has long been skeptical about psychiatry and unaccommodating to the evolution of diagnosis and classification of mental disorders. Unlike other areas of science,¹¹ courts are mistrustful of professional diagnoses of mental disorders¹² and treat forensic mental health professionals as “hired guns”¹³ or “professional elitists.”¹⁴ Making matters worse, relatively few trial attorneys understand how to establish the evidentiary foundation for mental health

⁵ *Id.* (emphasis added).

⁶ *Id.*

⁷ See Insel, *supra* note 1.

⁸ See *generally id.* (noting “that symptoms alone rarely indicate the best choice of treatment” for patients with mental disorders).

⁹ *Hall v. Florida*, 134 S. Ct. 1986, 2000 (2014) (holding that Florida’s definition of Intellectual Disability was unconstitutionally narrow and that a determination of Intellectual Disability must take into consideration prevailing medical practice).

¹⁰ See *id.* at 1998 (stating that “the States play a critical role in advancing protections and providing the Court with information that contributes to an understanding of how intellectual disability should be measured and assessed”).

¹¹ There is a stark dichotomy between the evidentiary treatment of mental health testimony and the treatment of all other scientific evidence. Expert opinion is readily accepted as fact in cases involving DNA, accident reconstruction, ballistics, and economic damages, for example. And many courts readily accept as fact expert testimony about pseudosciences like fingerprint, lie detector, or eyewitness identification techniques, which, if newly introduced, would not pass scrutiny under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 590 (1993).

¹² See *Greenwood v. United States*, 350 U.S. 366, 375 (1956) (“The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment . . .”).

¹³ The Federal Judicial Center surveyed trial judges regarding problems with expert testimony. “The most frequent problem cited by judges . . . was experts who ‘abandon objectivity and become advocates for the side that hired them.’” MOLLY TREADWAY JOHNSON ET AL., FED. JUDICIAL CTR., EXPERT TESTIMONY IN FEDERAL CIVIL TRIALS: A PRELIMINARY ANALYSIS 5 (2000), available at [http://www.fjc.gov/public/pdf.nsf/lookup/ExpTesti.pdf/\\$file/ExpTesti.pdf](http://www.fjc.gov/public/pdf.nsf/lookup/ExpTesti.pdf/$file/ExpTesti.pdf), archived at <http://perma.cc/PFH5-GPMQ>.

¹⁴ See *Hall*, 134 S. Ct. at 2002 (Alito, J., dissenting) (disagreeing with the majority’s reliance on “the evolving standards of professional societies, most notably the American Psychiatric Association” (emphasis omitted)); *infra* note 17.

testimony. Fewer still are able to competently challenge the basis for and substance of mental health experts' testimony.¹⁵

From a conceptual perspective, many consider science and medicine to be matters of fact, and consider law to be a matter of societal values. Diagnoses of mental disorders are often viewed askance due to this fact/value schism.¹⁶ Many view mental disorders with disdain, including judges and attorneys, who view mental illness to be the result of weakness, moral laxity, cunning, and self-interest.¹⁷ Many believe that mental illness can easily be feigned.¹⁸ Treatment regimen and the efficacy of mental health treatment are familiar to few outside the realm of psychiatry. Many in the field of forensic mental health, particularly expert witnesses who do not have an ongoing clinical practice, are confused themselves. The evolution in the understanding of mental illness naturally creates conflicting literature, which may further obscure the value and validity of informed mental health assessment.¹⁹

Going forward, Part II of this Article discusses the legal and scientific foundation of mental health experts' testimony. Part III describes common criminal law applications for mental health testimony and the relationship of the DSM-5 to these proceedings. Part IV explains the application of the diagnostic framework of the DSM-5 in cases where defendants claim protection from execution due to intellectual disability.

¹⁵ Possibly the most comprehensive reference for legal foundations of mental health evidence is *Coping with Psychiatric and Psychological Testimony*, by Dr. Jay Ziskin. The title alone conveys the sentiment that dealing with psychiatric and psychological testimony is a more arduous task than dealing with other forms of scientific evidence. See DAVID FAUST, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY* 5 (6th ed. 2012) (building upon the foundational works of Jay Ziskin).

¹⁶ See generally Bruce G. Link et al., *Measuring Mental Illness Stigma*, 30 *SCHIZOPHRENIA BULL.* 511 (2004) (discussing the conceptualization and measurement of stigma arising from mental illnesses).

¹⁷ See MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 244 (2000); Michael L. Perlin, "*Half-Wracked Prejudice Leaped Forth*": *Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 *J. CONTEMP. LEGAL ISSUES* 3, 15 (1999). Justice Alito suggests that the general public has experience and training in mental disorders: "Under our modern Eighth Amendment cases, what counts are our society's standards—which is to say, the standards of the American people—not the standards of professional associations, which at best represent the views of a small professional elite." *Hall*, 134 S. Ct. at 2005 (Alito J., dissenting).

¹⁸ Contrary to common belief, mental disorders are not easy to fake, especially when the deception must be sustained over a period of time. See Phillip J. Resnick, *Malingering*, in *PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY* 543, 544 (Richard Rosner ed., 2d ed. 2003); Michael L. Perlin, "*The Borderline Which Separated You From Me*": *The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 *IOWA L. REV.* 1375, 1404 (1997).

¹⁹ *Clark v. Arizona*, 548 U.S. 735, 776 (2006) ("Evidence of mental disease, then, can easily mislead . . . [O]pinions about mental disease may confuse a jury into thinking the opinions show more than they do.").

II. FOUNDATION

A. *Mental Health Experts and the Basis of Their Testimony*

Professional mental health organizations have published ethical codes and practice guidelines relevant to forensic testimony,²⁰ but there is no assurance that these guidelines or recommended diagnostic procedures will be followed in criminal proceedings. Forensic mental health experts include psychiatrists, psychologists, neurologists, social workers, and counselors.²¹ Mental health experts vary greatly in clinical experience and training. Postgraduate programs in forensic psychology and forensic psychiatry train mental health professionals to assess clients for legal purposes; however, a certificate in forensics does not guarantee actual training or clinical experience in diagnosis of any specific mental disorder.²² Courts have generally taken a “one-size-fits-all” approach for qualifying witnesses as mental health experts under Federal Rule of Evidence 702 and equivalent state statutes.²³ The result is that witnesses may be qualified as mental health experts who have little or no expertise with the clinical condition at issue²⁴:

²⁰ E.g., *THE DEATH PENALTY AND INTELLECTUAL DISABILITY* 3 (Edward A. Polloway ed., 2015). This book was recently published as a guide for clinicians and forensic mental health experts in capital cases where defendants claim Eighth Amendment protection from execution.

²¹ George W. Woods et al., *Neurobehavioral Assessment in Forensic Practice*, 35 INT’L J.L. & PSYCHIATRY 432, 433 (2012).

²² For example, *In re Robert Lewis Jr.* is a California capital habeas corpus case where the petitioner claimed protection from execution because of his intellectual disability. Referee’s Report at 1, *In re Robert Lewis Jr.*, No. A027897 (Cal. Super. Ct. Apr. 2, 2012). The prosecution “expert” testified that his only experience working with patients with intellectual disability was a brief period in graduate school where he was a case manager in a facility for individuals with varied mental health problems. Reporter’s Transcript of Proceedings at 1971–72, *In re Robert Lewis Jr.*, No. S117235 (Cal. June 24, 2011). The “expert” testified that he never administered standardized intelligence tests for the purpose of identifying intellectual disability. *Id.* at 1972–73. However, he was found qualified to testify as a forensic expert simply because he had “written hundreds of articles on different things” and had testified in other cases involving mental health. *Id.* at 1965–67.

²³ Per Federal Rule of Evidence 702, to qualify as an expert, a witness must establish his expertise by reference to “knowledge, skill, experience, training, or education.” FED. R. EVID. 702. However, this requirement has always been treated liberally. *In re Paoli R.R. Yard PCB Litig.*, 916 F.2d 829, 855 (3d Cir. 1990); cf. FED. R. EVID. 702 advisory committee’s note (“[T]he expert is viewed, not in a narrow sense, but as a person qualified by ‘knowledge, skill, experience, training or education.’”).

²⁴ Sophisticated understanding and the application of the best available mental health science cannot be assumed from simply holding a mental health credential. J. Gregory Olley, *Knowledge and Experience Required for Experts in Atkins Cases*, 16 APPLIED NEUROPSYCHOLOGY 135, 135–36 (2009).

To qualify as [a mental health] expert, the witness generally need not have any particular degree or type of experience or training; rather, courts consider the totality of the witness's education, training, and experience in the relevant field. Indeed, the qualifications requirement has been viewed as "minimal," and courts frequently hold that criticisms of or deficiencies in a witness's qualifications are matters for cross-examination at trial, affecting only the weight, not the admissibility, of the expert's testimony.²⁵

Diagnosis for legal purposes can be based on physical examination, structured interviews,²⁶ psychological and neuropsychological tests, imaging studies, laboratory tests, and previous medical and mental health records. Depending on the legal issue, an assessment may be retrospective, contemporaneous, or prospective. In the context of criminal cases, retrospective assessment is necessary to determine state of mind at the time of a crime, competency to waive legal rights,²⁷ postconviction competency to stand trial, and intellectual disability. Contemporaneous assessment is necessary to establish competence to stand trial or enter a plea,²⁸ to waive counsel, or to be executed.²⁹ Prospective assessments are speculative assessments conducted to determine setting bail and the likelihood of success or failure in rehabilitation, the required level of supervision, and the likelihood of being dangerous in the future as justification for a more punitive sentence.

For retrospective mental health assessment, careful review of prior medical, social, educational, employment, law enforcement, and social service records is essential for a competent and comprehensive assessment.³⁰ These records are also necessary for competent contemporaneous assessment, and recent medical and physical records, including laboratory test results, inform the assessment process.³¹ Regardless of its forensic aspiration, current standards in diagnostic procedure may require a thorough neuropsychological assessment and neurobehavioral assessment of cognitive function.³² A reliable diagnosis requires that an expert have education,

²⁵ FAUST, *supra* note 15, at 31–32 (citations omitted).

²⁶ Ethics guidelines in psychology warn that psychologists should avoid giving written or oral evidence about the psychological characteristics of a client when the expert has not conducted a personal examination. Comm. on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655, 663 (1991).

²⁷ I. Bruce Frumkin & Alfredo Garcia, *Psychological Evaluations and the Competency to Waive Miranda Rights*, 27 CHAMPION 12, 13 (2003).

²⁸ Pate v. Robinson, 383 U.S. 375, 378 (1966) (stating the Due Process Clause bars trial of a person who is mentally incompetent); Dusky v. United States, 362 U.S. 402, 402–03 (1960) (per curiam) (establishing the standard for competence to stand trial).

²⁹ Ford v. Wainwright, 477 U.S. 399, 417–18 (1986) (plurality opinion) (upholding the common law bar against executing the insane).

³⁰ See Woods et al., *supra* note 21, at 433 (stating the importance of a comprehensive social history in the diagnosis process relevant to the criminal or civil case).

³¹ *Id.* at 436–37.

³² *Id.* at 434–37.

training, and experience in selecting appropriate diagnostic procedures and interpreting the results.

B. Reliability of Experts' Diagnoses of Mental Disorders

An expert witness may testify about scientific evidence that is beyond the common understanding of a layperson.³³ Mental health experts may testify as to what scientific information they offer will be helpful and may assist the trier of fact in understanding and evaluating scientific evidence.³⁴ Evidence is only admissible if it is relevant,³⁵ and evidence is relevant only if it is reliable.³⁶

The reliability of a mental health expert's diagnosis refers to the extent to which two or more examiners would arrive at the same diagnosis.³⁷ Differences in experts' focus, bias, and technique can account for inconsistent diagnoses.³⁸ Also, an expert's motivation may result in confirmatory bias, which influences the reliability of the expert's mental health assessment.³⁹ Confirmatory bias refers to a tendency to look for evidence that supports a preconceived diagnosis or finding based on historical information, and to ignore later relevant information because the expert is preoccupied with confirming her initial diagnosis.⁴⁰ Pressure to form a particular diagnosis may be inherent in the forensic referral process. For example, a defense attorney may refer his client for forensic evaluation, saying, "This guy was clearly insane at the time of the offense, but tell me what you honestly think." Or a prosecutor may retain an expert to rule out the presence of intellectual disability, instructing, "This guy has low IQ scores but we know he's been malingering on IQ tests for years."

The DSM-5 lists twenty-two categories of mental disorders.⁴¹ With nine hundred pages of diagnostic material, it warns "this set of categorical diagnoses does not fully describe the full range of mental disorders that individuals experience and present to clinicians on a daily basis throughout the world."⁴² Indeed, diagnoses may have overlapping symptoms and similar presentations. And it is unlikely that

³³ FED. R. EVID. 701–02.

³⁴ FED. R. EVID. 702(a).

³⁵ FED. R. EVID. 402.

³⁶ See *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 590 (1993) (stating that "the requirement that an expert's testimony pertain to 'scientific knowledge' establishes a standard of evidentiary reliability").

³⁷ GARY GROTH-MARNAT, *HANDBOOK OF PSYCHOLOGICAL ASSESSMENT* 70 (5th ed. 2009).

³⁸ As Professor Faust points out, experts may base their conclusions on methods for which there is no research or where the scientific evidence is mixed. FAUST, *supra* note 15, at 7 ("[T]here seem to be almost infinite ways in which experts may alter, distort, mangle, or even flat-out disregard prescribed methodologies.").

³⁹ *Id.* at 305.

⁴⁰ *Id.*

⁴¹ See AM. PSYCHIATRIC ASS'N, *DSM-5*, *supra* note 3, at 27.

⁴² *Id.* at 19.

complex circumstances associated with criminal behavior are fairly represented in the diagnostic criteria. Thus, the likelihood of diagnosis agreement among mental health experts is low.

To understand the degree of diagnostic agreement among adversarial mental health experts, Professors Matthew Large and Olav Nielssen studied experts' reports in sixty-seven personal injury cases where there were opposing experts.⁴³

⁴³ Matthew M. Large & Olav Nielssen, *Factors Associated with Agreement Between Experts in Evidence About Psychiatric Injury*, 36 J. AM. ACAD. PSYCHIATRY L. 515, 516–17 (2008).

Table 1. Summary of the Large/Nielssen Study⁴⁴

In a study of sixty-seven personal injury cases following motor vehicle accidents, reports were written by psychiatrists or psychologists retained either by the plaintiff or defendant. Inter-rater agreement was measured by a κ (or kappa) statistic in the range of 0 to 1. A κ value of 0 indicated a level of agreement that may be expected by chance. A κ value of 1 indicated expert agreement in all cases. The level of agreement was scaled as follows:

- 0 to 0.2, poor agreement;
- 0.2 to 0.4, fair agreement;
- 0.4 to 0.6, moderate agreement;
- 0.6 to 0.8, good agreement; and
- 0.8 to 1.0, very good agreement.

Of the sixty-seven cases, forty-two had reports from two mental health experts, sixteen from three experts; eight from four experts; and one from five experts, for a total of 169 reports. Psychiatrists provided 119 reports; psychologists provided fifty. Fifty-six reports were from plaintiff's experts. Sixty-eight were from defendant's experts; forty-five were from treating psychologists or psychiatrists. There were 148 possible pairings of reports.

The study found:

- a) Mental health experts from the same adversarial side had good agreement about the presence of any mental disorder ($\kappa = .74$) but only fair agreement about a specific diagnosis ($\kappa = .31$).
- b) Mental health experts on opposite sides had poor agreement about the presence of any mental disorder ($\kappa = .09$) and poor agreement about a specific psychiatric diagnosis ($\kappa = .14$).
- c) Contrary to expectation, awareness of a previous mental health diagnosis appears to contribute to *lack of agreement* of experts, even experts from the same side.

The study concludes that error and bias are likely to be present in all forensic mental health examinations. Where error and bias are known to be present, it is essential to minimize bias wherever possible. A biased evaluation using accurate technique is always incorrect. Whereas, an objective assessment using erroneous technique may be correct.

The Large/Nielssen study demonstrates that skepticism about forensic mental health diagnoses is justified. There is poor agreement about both the presence of any given mental disorder and all specific psychiatric diagnoses in reports written by experts from opposing parties. Experts from the same parties had a greater degree

⁴⁴ *Id.* at 515–20.

of agreement about the presence of a psychiatric disorder but fair agreement about a specific diagnosis. The findings suggest the presence of both bias⁴⁵ and error⁴⁶ and suggest even “well-credentialed” psychiatrists and psychologists can reach an incorrect diagnosis.⁴⁷

Despite skepticism about reliability of evidence of mental disorders and frequent diagnostic disagreement, mental health testimony is a common feature in criminal cases.

⁴⁵ As to bias, the authors note,

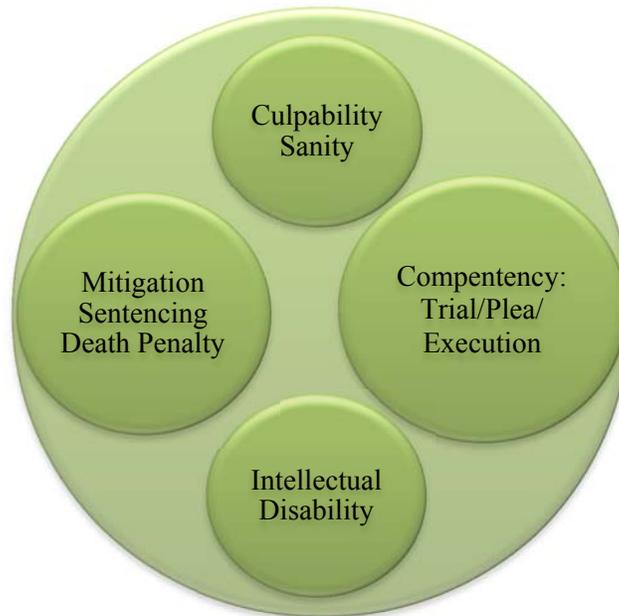
Advocates naturally select experts whose previous opinions are known to support a client’s case. Other possible sources include the understandable wish to please the hiring party, the financial inducement of the prospect of further work, and the nature of the instructions and the selection of documents given to the expert witness by the lawyer. The conclusions of medicolegal assessments may also be influenced by the interaction between expert and plaintiff.

Id. at 515.

⁴⁶ *Id.* at 520–21.

⁴⁷ John T. Philipsborn, *Selected Competence Related Rulings: Useful Lessons in Approaches to the Analysis of Competence to Stand Trial*, CAL. ATT’YS CRIM. JUST. FORUM, Sept. 2014, at 31, 37.

III. APPLICATION

A. *Use of Mental Disorder Diagnoses in Criminal Cases***Figure 1. In Criminal Cases, Where Will DSM-5 Make a Difference?**

Mental health testimony is common in the four areas of criminal proceedings illustrated above. Implications of the updated diagnostic structure of the DSM-5 vary by application.

In most criminal applications, a diagnosis of mental disorder will not resolve a legal question. Evidence of a mental disorder may inform the fact finder of cognitive impairment, perceptual problems, behavioral limitations, communication difficulties, and sensory dysfunction.⁴⁸ This information may contribute to understanding deficiencies in a defendant's decisional and performance capabilities. But, with a single exception, a diagnosis of mental disorder is not conclusive proof of a legal condition. Notably:

⁴⁸ The *Reference Manual on Scientific Evidence* notes that major diagnostic categories evidenced in legal proceedings are schizophrenia, dissociative disorder, bipolar disorder, major depressive disorder, substance disorders, personality disorders, antisocial personality disorder, organic brain disorders, intellectual disability, and dementia. FED. JUDICIAL CTR., NAT'L RESEARCH COUNCIL, *REFERENCE MANUAL ON SCIENTIFIC EVIDENCE* 831–33 (3d ed. 2011) [hereinafter *REFERENCE MANUAL ON SCIENTIFIC EVIDENCE*].

- Evidence of mental disease or disorder is a necessary but not sufficient element of insanity.⁴⁹
- Evidence of mental disease or disorder is not conclusive of incompetency to stand trial, enter into a plea agreement, waive counsel, or be executed.⁵⁰
- Evidence of mental disease or disorder may be introduced to mitigate punishment in criminal sentencing or in death penalty cases,⁵¹ but mental health evidence does not guarantee a favorable sentencing determination.⁵²
- Evidence of mental disease or disorder is often presented to support an assertion of “future dangerousness”⁵³ in order to justify continued civil commitment as a sex offender,⁵⁴ pedophile,⁵⁵ or mentally disordered offender.⁵⁶

Intellectual disability, the disorder previously known as mental retardation, is the *sole* mental disorder whose diagnosis resolves a legal dispute. In 2002, the U.S. Supreme Court issued its opinion in *Atkins v. Virginia*,⁵⁷ which categorically banned

⁴⁹ Definitions of insanity are generally based on the M’Naghten rule, which has a cognitive component: whether a mental defect prevents a defendant from understanding what he was doing; and it has a moral component: whether, due to a mental defect, a defendant is unable to understand that his action was wrong. *Clark v. Arizona*, 548 U.S. 735, 747, 750 (2006). Jurisdictions all incorporate one or both M’Naghten components. *Id.* at 750–52.

⁵⁰ The test for competency to stand trial is whether the defendant “has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him.” *Dusky v. United States*, 362 U.S. 402, 402 (1960) (per curiam). A prisoner is not competent to be executed if his mental state is so distorted by a mental illness that his awareness of the crime and punishment has little or no relation to the understanding of the community as a whole. *Panetti v. Quarterman*, 551 U.S. 930, 958–59 (2007).

⁵¹ A jury must be able to “consider and give effect to [a defendant’s] mitigating evidence of his mental retardation and abused childhood in rendering its sentencing decision.” *Penry v. Lynaugh*, 492 U.S. 302, 318 (1989).

⁵² See Yan Xuan & Kenneth J. Weiss, *Diminished Capacity: Mitigating or Aggravating Factor in Sentencing?*, 42 J. AM. ACAD. PSYCHIATRY & L. 242, 242–43 (2014).

⁵³ Psychiatric testimony is admissible to prove future dangerousness. See *Barefoot v. Estelle*, 463 U.S. 880, 903 (1983).

⁵⁴ In *Kansas v. Crane*, 534 U.S. 407 (2002), the U.S. Supreme Court held that a prisoner’s confinement may extend past his sentencing date if it can be proven beyond a reasonable doubt that he suffers from a mental disorder affecting his emotional or volitional capacity, which predisposes the person to commit sexually violent offenses. *Id.* at 410, 413.

⁵⁵ A current controversy with the DSM-5 involves the diagnosis of pedophilic disorder and the term pedophilic sexual orientation. Fred S. Berlin, *Pedophilia and DSM-5: The Importance of Clearly Defining the Nature of a Pedophilic Disorder*, 42 J. AM. ACAD. PSYCHIATRY & L. 404, 404 (2014).

⁵⁶ See, e.g., CAL. PENAL CODE §§ 2960–2981 (West 2011 & Supp. 2015) (authorizing continued commitment for a defendant with a severe mental disorder who is not in remission and was responsible for or contributed to a violent criminal act, so long as the defendant is a substantial danger of physical harm to others due to his mental disorder).

⁵⁷ 536 U.S. 304 (2002).

the death penalty for capital defendants who have intellectual disability.⁵⁸ The *Atkins* decision created a special class of defendants exempt from the death penalty, with inclusion in that class determined by a clinical diagnosis that is essentially made by a judge or jury, based largely on evidence from mental health experts. The DSM-5 revised the diagnostic criteria for intellectual disability to be consistent with the current definition of the American Association on Intellectual and Developmental Disabilities.⁵⁹ The DSM-5 definition and diagnostic criteria for intellectual disability were cited extensively in *Hall v. Florida*.⁶⁰

B. Mental Disorders in Insanity Cases

Insanity is a legal construct that does not have a one-to-one correspondence with any particular psychiatric diagnosis. In most jurisdictions, insanity is defined as an inability to appreciate the wrongfulness of one's actions or understand the nature and quality of the act at the time of a crime due to a mental disease or defect.⁶¹ Though testimony about disorders like schizophrenia or bipolar disorder can educate the fact finder about disease process and consequent cognitive and perceptual impairment, a diagnosis alone does not prove that a defendant was so impaired at the time of the crime to be unable to appreciate the wrongfulness of his conduct. A mere diagnosis is not sufficient to meet the legal requirements of insanity, but a mental disorder or defect is a necessary element in an insanity defense.⁶²

An insanity defense generally involves testimony by mental health professionals and may include evidence of prior mental disorders and of family history of mental disorders.⁶³ Because insanity describes a defendant's mental state at the time of the offense, evidence of a defendant's actions leading up to and following the event is crucial to a finding of insanity.⁶⁴ In general, mental health

⁵⁸ *Id.* at 318–20.

⁵⁹ THE DEATH PENALTY AND INTELLECTUAL DISABILITY, *supra* note 20, at 12–13.

⁶⁰ *See, e.g.*, 134 S. Ct. 1986, 1988, 1990, 1995, 2000, 2001, 2009 (2014).

⁶¹ The American Law Institute definition of insanity reads, “A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to either appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law.” MODEL PENAL CODE § 4.01(1) (1985) (alteration in original); *cf. infra* note 49.

⁶² In *Clark v. Arizona*, 548 U.S. 735 (2006), it was uncontested that the defendant, who shot and killed a police officer, suffered from paranoid schizophrenia. *Id.* at 745–46. Lay and expert testimony established that the defendant suffered from longstanding paranoid delusions, believing that Flagstaff, Arizona, was populated by aliens who wanted to kill him. *Id.* at 745. The defendant believed that the only way to protect himself was to kill the aliens with bullets. *Id.* Expert testimony established that the defendant believed the officer was an alien. *Id.* The prosecution was unable to establish that the defendant knew that the victim was a police officer. *Id.* at 746. However, the court (there was no jury) found that the defendant was not so impaired that he could not appreciate the wrongfulness of his actions and hence he was not insane. *Id.*

⁶³ REFERENCE MANUAL ON SCIENTIFIC EVIDENCE, *supra* note 48, at 820–21, 834.

⁶⁴ *Id.* at 817.

professionals are barred from testifying about the “ultimate issue”—that is, they may not state their opinion as to a defendant’s sanity or insanity at the time of a crime.⁶⁵

Despite the fact that the insanity defense dates back at least to the Code of Hammurabi,⁶⁶ the defense is the subject of derision by the prosecutorial community and the general public. A common belief, fostered by the media,⁶⁷ is that a defendant who is found not guilty by reason of insanity (“NGRI”) in some way gets off without punishment.⁶⁸ This belief is categorically untrue. In fact, NGRI defendants often spend more time in confinement than similarly charged and convicted persons.⁶⁹ Defendants found NGRI are required to undergo psychiatric treatment until they are returned to sanity.⁷⁰ Though a defendant may not be held in a psychiatric institution indefinitely without due process,⁷¹ a defendant with a history of insanity may be kept for life, if he is considered a danger to others.⁷² The federal courts and all but three states—Montana, Idaho and Utah—recognize the NGRI defense.

The insanity defense is raised in less than 1% of felony cases, and in only one in four of those cases is the defense successful.⁷³ Diagnoses of mental disorders—diagnoses based on the DSM—existed in 90% of all insanity cases.⁷⁴ It is likely that experts’ conflicting diagnoses, based on bias and error, create confusion for fact finders in insanity cases, leading to the low success rate of the defense.

⁶⁵ See FED. R. EVID. 704(b) (“In a criminal case, an expert witness must not state an opinion about whether the defendant did or did not have a mental state or condition that constitutes an element of the crime charged or of a defense. Those matters are for the trier of fact alone.”).

⁶⁶ Andrew Garofolo, *Early Implications of the Insanity Defense*, HIST. FORENSIC PSYCHOL., <http://historyforensicpsych.umwblogs.org/the-insanity-defense-outline-by-andrew-garofolo/early-implications-of-the-insanity-defense/>, archived at <http://perma.cc/2TJD-CVWT> (last visited Mar. 18, 2015); see also Eugene R. Milhizer, *Justification and Excuse: What They Were, What They Are, and What They Ought To Be*, 78 ST. JOHN’S L. REV. 724, 734–36 (2004).

⁶⁷ Richard A. Pasewark, *A Review of Research on the Insanity Defense*, ANNALS AM. ACAD. POL. & SOC. SCI., Mar. 1986, at 100, 101–02.

⁶⁸ See FAUST, *supra* note 15, at 535.

⁶⁹ See Joseph H. Rodriguez et al., *The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders*, 14 RUTGERS L.J. 397, 403–04 (1983) (finding that “NGRI defendants . . . spend considerably more time in custody than do other criminal defendants”).

⁷⁰ See, e.g., CAL. PENAL CODE § 1201(a) (West 2004 & Supp. 2015) (“If, upon the trial of that question, the jury finds that . . . [the defendant] is sane, judgment shall be pronounced, but if they find . . . [the defendant] insane, he or she shall be committed to the state hospital for the care and treatment of the insane, until he or she becomes sane . . .”).

⁷¹ See *Foucha v. Louisiana*, 504 U.S. 71, 82–83 (1992).

⁷² *Kansas v. Crane*, 534 U.S. 407, 412–13 (2002); *Kansas v. Hendricks*, 521 U.S. 346, 357–58 (1997).

⁷³ Lisa A. Callahan et al., *The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 331, 334–35 (1991).

⁷⁴ See *id.* at 337.

C. Mental Disorders and Culpability Analysis

Diagnoses of mental disorders may be used in establishing that a defendant, due to mental impairment or disorder, was unable to form the requisite mental state required to prove the crime.⁷⁵ Diminished capacity may also be considered in criminal sentencing. Under federal law, a more lenient sentence may be warranted if a defendant committed a crime while suffering from a serious mental illness (“SMI”), which significantly reduced the defendant’s mental capacity, and the reduced mental capacity contributed substantially to the commission of the offense.⁷⁶

The diagnoses included in the category of serious mental illness have long been a topic of debate. Does everyone with bipolar disorder have SMI? Does everyone with an eating disorder have SMI? Is intellectual disability an SMI? In 1992, the U.S. secretary of Health and Human Services developed the federal definition of SMI:

“[A]dults with a serious mental illness” are persons: [1] Age 18 and over, [2] [w]ho currently or at any time during the past year, [3] [h]ave had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within [the *Diagnostic and Statistical Manual of Mental Disorders*], [4] [t]hat has resulted in functional impairment which substantially interferes with or limits one or more major life activities. . . . All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.⁷⁷

⁷⁵ The diminished capacity defense has come under increased scrutiny following the notorious cases of *People v. White*, 172 Cal. Rptr. 612 (1981), and *United States v. Hinckley*, 525 F. Supp. 1342 (D.D.C. 1981). In *White*, the defendant killed San Francisco Supervisor Harvey Milk and Mayor George Moscone. *White*, 172 Cal. Rptr. at 614. White was convicted of voluntary manslaughter rather than murder. *Id.* at 615. White’s “Twinkie Defense” was a defense of diminished capacity due to severe depression. *See id.* As part of that defense, White’s defense team offered evidence of White’s excessive junk food consumption to establish the mental diagnosis of depression. Paul Krassner, *Behind the Twinkie Defense*, HUFFINGTON POST (Nov. 16, 2012, 6:24 PM), http://www.huffingtonpost.com/paul-krassner/behind-the-twinkie-defense_b_2147393.html, available at <http://perma.cc/WC65-RLYW>.

In *Hinckley*, the defendant was found NGRI of attempted murder of President Ronald Reagan. *Hinckley*, 525 F. Supp. at 1345. After reviewing evidence of increasingly bizarre behavior in the months prior to the shooting, the jury concluded that Hinckley’s mental disorder prevented him from appreciating the wrongfulness of his conduct. *Id.* at 1348.

For an extensive discussion on the insanity defense and its shortcomings, see Stephen J. Morse & Morris B. Hoffman, *The Uneasy Entente Between Legal Insanity and Mens Rea: Beyond Clark v. Arizona*, 97 J. CRIM. L. & CRIMINOLOGY 1071 (2007).

⁷⁶ U.S. SENTENCING GUIDELINES MANUAL § 5K2.13 (2014).

⁷⁷ Substance Abuse and Mental Health Services Administration, 58 Fed. Reg. 29,422, 29,425 (May 20, 1993) (citations omitted).

This broadly inclusive definition of SMI lends itself to interpretation by the fact finder, who often creates a hierarchy of “seriousness” of mental illnesses.

It is noteworthy that evidence of mental disorder does not necessarily lead to a lower sentence. For example, in *United States v. Lucas*,⁷⁸ the defendant, who was charged with assault with a deadly weapon, threats, and kidnapping, argued that he had diminished capacity due to Asperger’s syndrome, attention deficit hyperactive disorder, and bipolar disorder.⁷⁹ He claimed that he was in a manic state due to a reaction to the psychotropic drug Provigil and that his mental state was compromised.⁸⁰ The plea deal allowed for a sentence within the range of seven years to life imprisonment.⁸¹ The judge rejected Lucas’s diminished capacity argument.⁸² Indeed, the judge identified bad conduct that preceded the Provigil treatment and determined that Provigil did not create diminished capacity in the defendant.⁸³ The judge then found no mitigation by virtue of diminished capacity and sentenced Lucas to 17.5 years.⁸⁴

In conclusion, evidence of mental disorders is a critical component of an insanity defense. However the presence of a diagnosis, even in conjunction with delusional beliefs, may not persuade a fact finder of reduced culpability.

D. Guilty but Mentally Ill

“Guilty but mentally ill” (“GBMI”) is a legal construct that discards any requirement for a judge or jury to determine a defendant’s state of mind at the time of the commission of a crime.⁸⁵ GBMI was first established in Michigan in 1975, expressly to reduce the number of NGRI verdicts.⁸⁶ Now, twenty states have attempted to reduce NGRI verdicts by allowing the alternative verdict of GBMI.⁸⁷ The stated purpose of this verdict is to reduce the number of successful insanity defenses by offering an intermediate verdict between guilty and NGRI.⁸⁸

⁷⁸ 670 F.3d 784 (7th Cir. 2012).

⁷⁹ *Id.* at 788.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.* at 789.

⁸³ *Id.* at 789, 793.

⁸⁴ *Id.* at 789.

⁸⁵ See Morse & Hoffman, *supra* note 75, at 1122.

⁸⁶ Jennifer S. Bard, *Re-arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot Be Made Right by Piecemeal Changes to the Insanity Defense*, 5 HOUS. J. HEALTH L. & POL’Y 1, 37–38 (2005).

⁸⁷ *Id.*

⁸⁸ See Scott Leigh Sherman, *Guilty but Mentally Ill: A Retreat from the Insanity Defense*, 7 AM. J.L. & MED. 237, 254 (1981).

The definition of GBMI varies from state to state. Some states define GBMI as “not insane but was suffering from a mental illness.”⁸⁹ GBMI gives jurors the impression that there is an intermediate verdict between guilty and NGRI, and provides an avenue to avoid the ethical conflict many feel about the insanity defense. Studies show jurors believe that a finding of GBMI in some way diminishes the culpability of a defendant⁹⁰ and gives the illusion of compassionate treatment of a criminal defendant. In fact, a defendant who pleads NGRI and is found GBMI often receives a harsher sentence than those who are simply found guilty.⁹¹ In the majority of GBMI verdicts, the defendant receives no psychiatric or mental health treatment,⁹² clearly in violation of *Estelle v. Gamble*.⁹³ The American Psychiatric Association,⁹⁴ American Psychological Association,⁹⁵ and American Bar Association⁹⁶ all oppose the GBMI verdict.

E. Mental Disorders in the Consideration of Competence to Be Executed

In *Ford v. Wainwright*,⁹⁷ the U.S. Supreme Court held that executing a person who is presently incompetent violates the Eighth Amendment’s protection against cruel and unusual punishment.⁹⁸ There, in accordance with Florida law, three state-appointed psychiatrists interviewed Ford, a condemned inmate.⁹⁹ But contrary to the evidence,¹⁰⁰ Ford was found to have the mental capacity to understand the nature of

⁸⁹ 720 ILL. COMP. STAT. ANN. 5/6-2(c) (West 2002 & Supp. 2014).

⁹⁰ NORMAN J. FINKEL, COMMONSENSE JUSTICE: JURORS’ NOTIONS OF THE LAW 295–96 (1995); Norman J. Finkel & Solomon M. Fulero, *Insanity: Making Law in the Absence of Evidence*, 11 MED. & L. 383, 395–97, 400 (1992).

⁹¹ Lisa A. Callahan et al., *Measuring the Effects of the Guilty but Mentally Ill (GBMI) Verdict*, 16 LAW & HUM. BEHAV. 447, 447, 449 (1992).

⁹² See Hanke Gratteau, *Little Help for ‘Guilty but Mentally Ill’*, CHI. TRIB. (Apr. 30, 1985), http://articles.chicagotribune.com/1985-04-30/news/8501260304_1_mental-health-illinois-department-guilty, archived at <http://perma.cc/CST3-978K>.

⁹³ 429 U.S. 97, 103–04 (1976) (holding that prisoners have a right to medical care).

⁹⁴ AM. PSYCHIATRIC ASS’N, POSITION STATEMENT ON THE INSANITY DEFENSE 1 (2007), available at <http://www.psychiatry.org/File%20Library/Learn/Archives/Position-2007-Insanity-Defense.pdf>, archived at <http://perma.cc/D3SS-ZH8H>.

⁹⁵ *Council Policy Manual: Chapter XII. Public Interest (Part 1)*, AM. PSYCHOLOGICAL ASS’N, <http://www.apa.org/about/policy/chapter-12.aspx>, archived at <http://perma.cc/3GUY-AM2F> (last visited Apr. 1, 2015).

⁹⁶ See *Mental Health*, AM. BAR ASS’N, available at http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_mentalhealth_blk.html, archived at <http://perma.cc/7KWJ-BHF7> (last visited Apr. 1, 2015) (“Statutes which supplant or supplement the verdict of not guilty by reason of mental nonresponsibility [insanity] with a verdict of guilty but mentally ill should not be enacted.” (alteration in original)).

⁹⁷ 477 U.S. 399 (1986).

⁹⁸ *Id.* at 409–10.

⁹⁹ *Id.* at 403–04.

¹⁰⁰ Consider this segment of the transcript of the experts’ interview and report:

the death penalty and the reason it was imposed.¹⁰¹ And under Florida law, Ford had no opportunity to cross-examine the State's handpicked experts.¹⁰² The U.S. Supreme Court was skeptical of the fundamental fairness of the process:

Cross-examination of the psychiatrists, or perhaps a less formal equivalent, would contribute markedly to the process of seeking truth in sanity disputes by bringing to light the bases for each expert's beliefs, the precise factors underlying those beliefs, any history of error or caprice of the examiner, any personal bias with respect to the issue of capital punishment, the expert's degree of certainty about his or her own conclusions, and the precise meaning of ambiguous words used in the report. Without some questioning of the experts concerning their technical conclusions, a factfinder simply cannot be expected to evaluate the various opinions, particularly when they are themselves inconsistent.¹⁰³

The guard stands outside my cell and reads my mind. Then he puts it on tape and sends it to the Reagans and CBS . . . I know there is some sort of death penalty, but I'm free to go whenever I want because it would be illegal and the executioner would be executed . . . CBS is trying to do a movie about my case . . . I know the KKK and news reporters all disrupting me and CBS knows it. Just call CBS crime watch . . . there are all kinds of people in pipe alley (an area behind Mr. Ford's cell) bothering me—Sinatra, Hugh Hefner, people from the dog show, Richard Burr, my sisters and brother trying to sign the death warrants so they don't keep bothering me . . . I never see them, I only hear them especially at night. (Note that Mr. Ford denies *seeing* these people in his delusions. This suggests that he is honestly reporting what his mental processes are.) I won't be executed because of no crime . . . maybe because I'm a smart ass . . . my family's back there (in pipe alley) . . . you can't evaluate me. I did a study in the army . . . a lot of masturbation . . . I lost a lot of money on the stock market. They're back there investigating my case. Then this guy motions with his finger like when I pulled the trigger. Come on back you'll see what they're up to—Reagan's back there too. Me and Gail bought the prison and I have to sell it back. State and federal prisons. We changed all the other counties and because we've got a pretty good group back there I'm completely harmless. That's how Jimmy Hoffa got it. My case is gonna save me.

Brief for Petitioner at 4 n.4, *Ford*, 477 U.S. 399 (No. 85-5542) (noting that the comments in parenthesis are those of Dr. Kaufman). “Dr. Barnard agreed with Dr. Halleck and further concluded that Dr. Ivory's crucial inferential finding, that Mr. Ford was feigning psychosis because his cell was far better organized than his thought processes seemed to be . . . had no basis in the medical literature.” *Id.* at 5 (citations omitted).

¹⁰¹ *Ford*, 477 U.S. at 404.

¹⁰² *Id.* at 415 (plurality opinion).

¹⁰³ *Id.*; see also *Barefoot v. Estelle*, 463 U.S. 880, 899 (1983) (stating that there are doctors who are willing to testify at sentencing hearings whose opinions are inconsistent with each other and the American Psychiatric Association's views).

Ford restated the common law¹⁰⁴ and established that a competency assessment is subject to due process and Eighth Amendment protection from arbitrary punishment.¹⁰⁵ However, *Ford* refrained from defining how the law should determine who is presently competent.

Twenty-one years later, in *Panetti v. Quarterman*,¹⁰⁶ the U.S. Supreme Court addressed the issue of competence to be executed with increased specificity. Texas resident, Scott Panetti, had a long history of schizophrenia and involuntary commitments for psychiatric treatment.¹⁰⁷ He was accused of capital murder for killing his in-laws.¹⁰⁸ Despite being delusional, the trial court found Panetti competent to stand trial and to represent himself.¹⁰⁹ Panetti wore a cowboy suit to court and attempted to subpoena Jesus Christ, Anne Bancroft, and John F. Kennedy.¹¹⁰ Panetti was convicted and sentenced to death.¹¹¹ In habeas corpus, Panetti claimed that he was incompetent to stand trial and incompetent to be

¹⁰⁴ Blackstone explained the common law rule as follows:

[I]f a man in his [s]ound memory commits a capital offence, and before arraignment for it, he becomes mad, he ought not to be arraigned for it; becau[s]e he is not able to plead to it with that advice and caution that he ought. And if, after he has pleaded, the pri[s]oner becomes mad, he [s]hall not be tried; for how can he make his defence? If, after he be tried and found guilty, he lo[s]es his [s]en[s]es before judgment, judgment [s]hall not be pronounced; and if, after judgment, he becomes of non[s]ane memory, execution [s]hall be [s]tayed: for peradventure, [s]ays the humanity of the Engli[s]h law, had the pri[s]oner been of [s]ound memory, he might have alleged [s]omething in [s]tay of judgment or execution.

4 WILLIAM BLACKSTONE, COMMENTARIES *24–25 (citations omitted).

¹⁰⁵ *Ford*, 477 U.S. at 409–10; *id.* at 413–14 (plurality opinion).

¹⁰⁶ 551 U.S. 930 (2007).

¹⁰⁷ *Id.* at 936. For a recitation of Panetti’s history of mental disorders presented in his state court post-conviction proceedings, see Brief for Respondent at 3–10, *Panetti*, 551 U.S. 930 (No. 06-6407), 2007 WL 978432, at *3–10.

¹⁰⁸ *Panetti*, 551 U.S. at 935–36.

¹⁰⁹ *Id.* at 936.

¹¹⁰ *Ex parte Panetti*, 326 S.W.3d 615, 617–18 n.4 (Tex. Crim. App. 2010) (per curiam) (“Scott dressed in a ‘Tom Mix’ style costume like an old TV western. Scott wore his hat in Court. He had pants that looked like leather suede tucked into his cowboy boots. He wore a cowboy style shirt with a bandana. The shirt was the double fold over type western shirt. One shirt was a green color, the other was burgundy. Scott wore a big cowboy hat that hung on a string over his back. It was a joke. It was like out of a dime store novel. Scott constantly used an old west vernacular in his speech. He used words like ‘bronc steer,’ ‘run away mule,’ and ‘shoe the bosses’ hosses.” (quoting Panetti’s standby counsel’s affidavit filed at trial)); Chase Hoffberger, *Death Watch: Executing the Mentally (and Physically) Ill*, AUSTIN CHRON. (Nov. 28, 2014), <http://www.austinchronicle.com/news/2014-11-28/deathwatch-executing-the-mentally-and-physically-ill/>, archived at <http://perma.cc/86CV-KZRZ>.

¹¹¹ *Panetti*, 551 U.S. at 937.

executed.¹¹² The trial courts disagreed.¹¹³ After lengthy habeas corpus proceedings, the Court ruled that, to be executed, Panetti was required to have a “rational understanding” of the death sentence and why it was imposed, among other factors.¹¹⁴ “Gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose.”¹¹⁵ Panetti was granted the opportunity for a competency evaluation.¹¹⁶ Though he was profoundly psychotic, the trial court found that he was competent to be executed but his sentence was stayed pending further proceedings.¹¹⁷ In 2013, the Fifth Circuit upheld the district court’s finding of competency to be executed.¹¹⁸ His attorneys filed a petition for a writ of certiorari with the U.S. Supreme Court, which the Court denied.¹¹⁹ But his request for a stay of execution pending further proceedings has been granted.¹²⁰

Despite predictions to the contrary, relatively few death-sentenced inmates assert that they are not competent to be executed. In some successful cases, evidence suggests that where a rightful claim of incompetence to stand trial was asserted and denied, it is likely that the defendant was incompetent for all purposes.¹²¹ Most successful claims of incompetence for execution follow on the heels of prior claims of incompetence.¹²² It is estimated that between 5 and 10% of death row inmates suffer from serious mental illness but only 6.7% have filed claims of protection from execution due to incompetency.¹²³

Despite diagnoses of profound mental illness, there are many stories of condemned inmates who seem to fit the *Panetti* framework of incompetence.¹²⁴ The majority of these inmates suffer from schizophrenic spectrum and other psychotic

¹¹² *Id.* at 937–38.

¹¹³ *Id.*

¹¹⁴ *See id.* at 958–60.

¹¹⁵ *Id.* at 960.

¹¹⁶ *Panetti v. Quarterman*, No. A-04-CA-042-SS, 2008 WL 2338498, at *1 (W.D. Tex. Mar. 26, 2008), *aff’d sub nom. Panetti v. Stephens*, 727 F.3d 398 (5th Cir. 2013), *cert. denied*, 135 S. Ct. 47 (2014).

¹¹⁷ *Id.* at *37.

¹¹⁸ *Panetti*, 727 F.3d at 410–13.

¹¹⁹ *Panetti*, 135 S. Ct. at 47.

¹²⁰ *Panetti v. Stephens*, 586 F. App’x 163, 164 (5th Cir. 2014) (per curiam).

¹²¹ *See* John H. Blume et al., *Killing the Oblivious: An Empirical Study of Competency to Be Executed Litigation*, 82 UMKC L. REV. 335, 356–57 (2014).

¹²² *Id.* at 356.

¹²³ *Id.* at 354.

¹²⁴ *E.g.*, Marc Bookman, *13 Men Condemned to Die Despite Severe Mental Illness*, MOTHER JONES (Feb. 12, 2013, 7:02 AM), <http://www.motherjones.com/politics/2013/01/death-penalty-cases-mental-illness-clemency>, archived at <http://perma.cc/87VJ-6ZFA>.

disorders,¹²⁵ as well as bipolar disorder.¹²⁶ However, these diagnoses are not guaranteed to stop their executions. Table 2 provides examples of those who were likely incompetent for execution.¹²⁷

Table 2. Inmates Sentenced for Execution Likely Incompetent

Inmate	State	Crime Date	Diagnosis	Psychiatric Symptoms	Status
Johnny Frank Garrett	Texas	1981	Paranoid schizophrenia	Lethal injection would not kill him. Supernatural intervention by a long-dead aunt would counteract the lethal chemicals.	Executed in 1992
Larry Keith Robison	Texas	1982	Paranoid schizophrenia	Auditory hallucinations told him that he was a part of the apocalypse and his death would liberate many souls so that he could be liberated.	Executed in 2000
Monty Allen Delk	Texas	1986	Bipolar disorder	He was the president of Kenya and a submarine commander. Last words: "I am the warden. Get your warden off this gurney. You are not in America. This is the island of Barbados."	Executed in 2002

¹²⁵ *Id.* Schizophrenia Spectrum and other psychotic disorders are thought disorders, which may involve delusions, hallucinations, disorganized thinking and disorganized motor behaviors. AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 87.

¹²⁶ Bookman, *supra* note 124. Bipolar disorder has symptoms that may overlap with those of both schizophrenia spectrum disorders and depressive disorders. AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 123.

¹²⁷ Bookman, *supra* note 124.

Inmate	State	Crime Date	Diagnosis	Psychiatric Symptoms	Status
James Blake Colburn	Texas	1994	Paranoid schizophrenia	So drugged at trial that he snored through the trial. When not medicated he ate his own feces.	Executed in 2003
Kelsey Patterson	Texas	1992	Paranoid schizophrenia	He was controlled by an electronic implant. Parole board recommended sentence commutation based on mental illness.	Executed in 2004
Steven Staley	Texas	1989	Paranoid schizophrenia	Had grandiose and paranoid delusions. He invented the first car. Smears feces in his cell. Involuntarily medicated.	Execution pending
Guy Tobis LeGrande	North Carolina	1993	Delusional disorder	Believed he could communicate with Oprah through the TV. Represented himself at trial wearing a Superman T-shirt. Called the jurors "Antichrists".	Found not competent to be executed
George Emil Banks	Pennsylvania	1982	Psychotic disorder	Believed the government was trying to poison him. His death sentences had been vacated by God, Jesus, and G.W.Bush.	On death row
Calvin Eugene Swann	Virginia	1992		Talked to animals and spoke in numbers. Institutionalized from childhood. Behavior on	Sentence commuted in 1999

Inmate	State	Crime Date	Diagnosis	Psychiatric Symptoms	Status
				death row was “bizarre and devoid of rationality.”	
Alexander E. Williams	Georgia	1986	Paranoid schizophrenia	Saw little men in his cell, talked to animals, and thought Sigourney Weaver was God.	Sentence commuted in 2002; hung himself later
Arthur Paul Baird	Indiana	1985		Claimed to have solved the nation’s debt and was owed \$1 million reward from the government. God would turn back time and bring his victims back.	Sentence commuted in 2005
Percy Levar Walton	Virginia	1996	Schizophrenia	He was Superman, Jesus and the Bible was written about him. Execution would bring him and his victims back to life.	Sentence commuted in 2008

F. Mental Disorders in the Context of Competence to Stand Trial, Enter a Plea, and Waive Counsel

Competency to stand trial requires that a defendant have both a rational understanding of the legal proceedings against him and an ability to communicate effectively with his attorney.¹²⁸ A defendant must have “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and have “a rational as well as factual understanding of the proceedings against him.”¹²⁹ In practice, the ability to effectively participate in one’s defense is crux of competence.

For example, in *Dusky v. United States*,¹³⁰ the petitioner was referred for evaluation by his attorney.¹³¹ The state psychiatric facility found him psychotic with

¹²⁸ *Dusky v. United States*, 362 U.S. 402, 402–03 (1960) (per curiam).

¹²⁹ *Id.* at 402 (quoting the Solicitor General’s statements in the record).

¹³⁰ 271 F.2d 385 (8th Cir. 1959).

¹³¹ *Id.* at 387.

auditory and visual hallucinations and diagnosed him with schizophrenia.¹³² Despite uncontested evidence that he was unable to assist trial counsel, Dusky was found competent, tried, and convicted.¹³³

One year later, the U.S. Supreme Court questioned the value of psychiatric evidence of competence to stand trial but agreed that the record deserved further review:

In view of the doubts and ambiguities regarding the legal significance of the psychiatric testimony in this case and the resulting difficulties of retrospectively determining the petitioner's competency as of more than a year ago, we reverse the judgment of the Court of Appeals affirming the judgment of conviction, and remand the case to the District Court for a new hearing to ascertain petitioner's present competency to stand trial, and for a new trial if petitioner is found competent.¹³⁴

In addition, from 1996 to 1998, the National Institute of Mental Health in conjunction with the John D. and Catherine T. MacArthur Foundation investigated adult competence to stand trial. One outcome was the MacArthur Competence Assessment Tool—Criminal Adjudication (MacCAT-CA).¹³⁵ The study determined:

- Approximately 10 percent of all criminal defendants are perceived by their attorneys as having potentially impaired competence. . . . [D]efendants of doubtful competence are usually not referred by their attorneys for a formal mental health evaluation.
- A defendant may need several different capacities to be competent to proceed with criminal adjudication It is not sufficient to assess only one capacity to evaluate adjudicative competence: a defendant with mental disorder may not have an impairment on the assessed capacity, even though other capacities required for adjudicative competence are impaired.
- A person whose competence is impaired for one legal purpose . . . does not necessarily lack competence for other legal purposes (e.g., adjudicating his or her criminal case). Conversely, a person who is competent for one legal purpose may have impairments in competence for other legal purposes.
- While no clinical diagnosis by itself indicates incompetence, competence-related impairments regarding criminal adjudication are

¹³² *Id.* at 387–89.

¹³³ *Id.* at 386–87, 389.

¹³⁴ *Dusky*, 362 U.S. at 403.

¹³⁵ *The MacArthur Adjudicative Competence Study*, MACARTHUR RES. NETWORK ON MENTAL HEALTH & L., <http://www.macarthur.virginia.edu/adjudicate.html>, archived at <http://perma.cc/HUY7-L7V3> (last visited Apr. 1, 2015).

strongly associated with symptoms of severe mental disorder, and particularly with a diagnosis of schizophrenia. . . .

- When defendants hospitalized for restoration of competence were retested with [the MacCAT-CA], significant improvement in decision making abilities was observed for those defendants who were treated and referred back to court as having been restored to competence. . . .
- Empirical information is now available to inform judges and legislators as they set [legal] standards [for competence].¹³⁶

“For clinical information to be relevant in addressing legal questions of competence, *examiners must present the logic that links these observations to the specific abilities and capacities with which the law is concerned.*”¹³⁷ Though standardized measurements of competence suggest an objective assessment, there is still a prevalence of the attitude that “I’ll know it when I see it”¹³⁸ in a determination of competence to stand trial. Competence to enter a plea is held to the same standard as competency to stand trial.¹³⁹

In setting a standard of competence to stand trial, the Court has focused directly upon a defendant’s ability to consult with his lawyer.¹⁴⁰ *Dusky* suggests that choosing to forgo trial counsel presents a different set of circumstances than the mental competency determination for a defendant to stand trial.¹⁴¹

*Indiana v. Edwards*¹⁴² recognized that the nature of a defendant’s mental illness may “vary over time” and interfere with a defendant’s “functioning at different times in different ways.”¹⁴³ *Edwards* cautions against the use of a single competency standard to decide “both whether a defendant who is represented can proceed to trial and whether a defendant who goes to trial must be permitted to represent himself.”¹⁴⁴

Finally, competency to stand trial, particularly in death penalty cases, is a frequent subject of litigation in habeas corpus. *Dusky*, *Panetti*, and *Edwards* demonstrate that the prospect of successful retrospective assessment of competency is dim.

¹³⁶ *Id.*

¹³⁷ THOMAS GRISSO, *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS* 13 (2d ed. 2003).

¹³⁸ See JOHN PARRY, *CRIMINAL MENTAL HEALTH AND DISABILITY LAW, EVIDENCE AND TESTIMONY* 61–62, 297 (2009) (stating that there are still a number of judges who apply competence measurements subjectively on a case-by-case basis).

¹³⁹ *Godinez v. Moran*, 509 U.S. 389, 399 (1993).

¹⁴⁰ “[T]he test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” *Dusky v. United States*, 362 U.S. 402, 402 (1960) (per curiam) (quoting the Solicitor General’s statements in the record).

¹⁴¹ See *id.* at 402–03.

¹⁴² 554 U.S. 164 (2008).

¹⁴³ *Id.* at 175.

¹⁴⁴ *Id.* at 165.

G. Mental Disorders in the Context of Death Penalty Mitigation

The death penalty is limited to offenders who commit the most serious crimes, “whose extreme culpability makes them ‘the most deserving of execution.’”¹⁴⁵ Sentencing decisions in capital cases are supposed to be based on individualized considerations of the offender and the crime.¹⁴⁶ Jurors are required to consider circumstances that make a death sentence more appropriate (aggravating factors) and circumstances that make a life sentence more appropriate (mitigating factors).¹⁴⁷ Mitigating factors can include “any aspect of a defendant’s character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death.”¹⁴⁸ Mitigating factors involving mental health experts include mental illness, intellectual impairments, family mental health history, and childhood trauma.¹⁴⁹ Aggravating factors are defined by statute¹⁵⁰ and, in some states, there are so many statutory aggravating factors that most murders would qualify for the death penalty.¹⁵¹

¹⁴⁵ Kennedy v. Louisiana, 554 U.S. 407, 420 (2008) (quoting Roper v. Simmons, 543 U.S. 551, 568 (2005)).

¹⁴⁶ Gregg v. Georgia, 428 U.S. 153, 199 (1976) (plurality opinion).

¹⁴⁷ *Id.* at 196–97.

¹⁴⁸ Lockett v. Ohio, 438 U.S. 586, 604 (1978) (plurality opinion). For example, the Model Penal Code mitigating factors cited in *Gregg* include the following:

The defendant has no significant history of prior criminal activity. . . . The murder was committed while the defendant was under the influence of extreme mental or emotional disturbance. . . . The victim was a participant in the defendant’s homicidal conduct or consented to the homicidal act. . . . The murder was committed under circumstances which the defendant believed to provide a moral justification or extenuation for his conduct. . . . The defendant was an accomplice in a murder committed by another person and his participation in the homicidal act was relatively minor. . . . The defendant acted under duress or under the domination of another person. . . . At the time of the murder, the capacity of the defendant to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law was impaired as a result of mental disease or defect or intoxication. . . . The youth of the defendant at the time of the crime.

Gregg, 428 U.S. at 193–94 n.44 (plurality opinion) (alteration in original) (citation omitted).

¹⁴⁹ See MICHAEL L. PERLIN, MENTAL DISABILITY AND THE DEATH PENALTY: THE SHAME OF STATES 30–31 (2013) (listing the four-part test created from *Gregg* by Professor James Liebman); see also *Gregg*, 428 U.S. at 193–94 n.44 (plurality opinion) (noting the Model Penal Code mitigating factors that may be considered in death penalty sentencing).

¹⁵⁰ For a list of aggravating factors, see *Aggravating Factors for Capital Punishment by State*, DEATH PENALTY INFO. CENTER, <http://www.deathpenaltyinfo.org/aggravating-factors-capital-punishment-state>, archived at <http://www.perma.cc/SB27-SS7X> (last visited Mar. 2, 2015).

¹⁵¹ See, e.g., CAL. PENAL CODE § 190.2 (West 2014 & Supp. 2015) (listing twenty-two different circumstances that make a crime suitable for the death penalty).

Perhaps more so than in most other criminal proceedings, evidence of mental illness is a major component of mitigation.¹⁵² This is not to say that evidence of mental illness is determinative of a sentence of life imprisonment. Of the last one hundred offenders executed before June 2014, evidence showed that fifty-four “had been diagnosed with or displayed symptoms of severe mental illness.”¹⁵³ Among those, “six . . . were diagnosed with schizophrenia, three with bipolar disorder, and nine with post-traumatic stress disorder.”¹⁵⁴ Six had attempted suicide.¹⁵⁵ And the most prevalent mental illness was chronic drug addiction.¹⁵⁶ The evidence demonstrated that their mental illnesses impaired their “ability to think clearly, manage emotions, make decisions, [and] relate to others, and cause[d] unpredictable and disorganized behavior.”¹⁵⁷

Evidence of mental disorder or impairment is used both as a sword and a shield in capital cases.¹⁵⁸ Studies demonstrate that two substantive issues are the primary subjects of mental health testimony in capital sentencing.¹⁵⁹ First, evidence of mental illness or impairment is offered to reduce the defendant’s culpability to the degree that execution would not be appropriate—that is, to show that the defendant is not “the worst of the worst.”¹⁶⁰ In rebuttal, the State offers evidence of the likelihood that a defendant will continue to be dangerous—“future dangerousness”—to persuade the jury that execution is justified.¹⁶¹ Note that future dangerousness has been shown to play a prominent role in jury deliberations, even to the extent that it may overshadow mitigating evidence.¹⁶²

¹⁵² PERLIN, *supra* note 149, at 30 (“The importance of mitigating evidence at the penalty stage ‘cannot be overestimated’.” (quoting Welsh S. White, *Capital Punishment’s Future*, 91 MICH. L. REV. 1429, 1434 (1992))).

¹⁵³ Robert J. Smith et al., *The Failure of Mitigation?*, 65 HASTINGS L. J. 1221, 1241–1245 (2014).

¹⁵⁴ *Id.* at 1245 (citations omitted).

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* (citation omitted).

¹⁵⁸ PERLIN, *supra* note 149, at 33 (“[M]itigating evidence is any evidence that the jury could reasonably find warrants a sentence less than death.”).

¹⁵⁹ See John H. Montgomery et al., *Expert Testimony in Capital Sentencing: Juror Responses*, 33 J. AM. ACAD. PSYCHIATRY L. 509, 510 (2005).

¹⁶⁰ *Roper v. Simmons*, 543 U.S. 551, 568 (2005) (“Capital punishment must be limited to those offenders who commit ‘a narrow category of the most serious crimes’ and whose extreme culpability makes them ‘the most deserving of execution.’” (quoting *Atkins v. Virginia*, 536 U.S. 304, 319 (2002))).

¹⁶¹ *Barefoot v. Estelle*, 463 U.S. 880, 896 (1983). Future dangerousness is arguably inadmissible due to irrelevance. Predictions of future dangerousness are, by nature, purely speculative, and rarely correct. Justice Blackmun, in his dissent, noted that in the prediction of future dangerousness “such testimony is wrong two times out of three.” *Id.* at 916 (Blackmun, J., dissenting).

¹⁶² See John H. Blume et al., *Future Dangerousness in Capital Cases: Always “At Issue”*, 86 CORNELL L. REV. 397, 404 (2001).

Professor John H. Montgomery and his colleagues studied the influence of prosecution and defense mental health experts on jurors' assessment of a defendant's dangerousness, mental stability or craziness, severity of a crime, and remorse—significant aggravating or mitigating issues where mental health evidence was likely to be influential.¹⁶³ The results of this study were surprising:

- “Psychiatric expert testimony presented by the prosecution during penalty phases did not significantly correlate with jurors’ impressions of a defendant’s future dangerousness”¹⁶⁴
- “Psychiatric expert testimony presented by the defense during the penalty phases significantly and positively correlated with jurors’ impressions of a defendant’s mental abnormality”¹⁶⁵
- A “defendant’s perceived dangerousness, craziness, and instability on average were less when neither state nor defense psychiatric testimony was presented.”¹⁶⁶
- A defendant’s perceived lack of remorse correlated significantly with a finding of future dangerousness.¹⁶⁷
- Defense psychiatric testimony positively influenced a juror’s assessment of craziness (i.e., defendant “went crazy when he committed the crime”). State psychiatric testimony had little influence when defense psychiatric testimony was presented on the issue of craziness.¹⁶⁸
- Defense psychiatric testimony positively influenced a juror’s assessment of mental instability, (i.e., “defendant is mentally unstable or disturbed”). State psychiatric testimony had little influence when defense psychiatric testimony was presented on the issue of craziness.¹⁶⁹

Though testimony from mental health experts may suggest a variety of diagnoses, no single diagnosis has been proven to correlate one to one with a finding of future dangerousness.

However, the artificial and unscientific characterization of a defendant as a “psychopath” is strongly correlated with a juror’s belief that a defendant is likely to be violent in the future.¹⁷⁰ Psychopathy is not a diagnosis in the DSM. But the behaviors associated with psychopathy are most closely aligned with the DSM-5 diagnosis of antisocial personality disorder (301.7).¹⁷¹

¹⁶³ Montgomery et al., *supra* note 159, at 516.

¹⁶⁴ *Id.* at 512.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* at 513.

¹⁶⁷ *Id.* at 514.

¹⁶⁸ *Id.* at 515–16.

¹⁶⁹ *Id.* at 515.

¹⁷⁰ John F. Edens et al., *Effects of Psychopathy and Violence Risk Testimony on Mock Juror Perceptions of Dangerousness in a Capital Murder Trial*, 10 PSYCHOL. CRIME & L. 393, 397 (2004).

¹⁷¹ See AM. PSYCHIATRIC ASS’N, DSM-5, *supra* note 3, at 659.

Psychopathy is typically determined by comparing a defendant's history with the two-factor model of the Hare Psychopathy Checklist (PCL). In its latest revision, the PCL-R, a defendant is assessed for certain interpersonal and affective characteristics, and for lifestyle and antisocial characteristics.¹⁷² It is suggested that the results of the assessment correlate with characteristics of antisocial personality disorder, such as impulsivity, aggression, and criminal behavior; lack of empathy; lack of remorse; deceitfulness; and failure to accept responsibility.¹⁷³

There is considerable debate about the construct of psychopathy.¹⁷⁴ In questioning the conceptual validity of the usefulness of psychopathy for forensic purposes, Professor Don Fowles of the University of Iowa notes:

It is *not impossible* that there is some value in making diagnoses of psychopathy in a forensic context, but this review should give everyone pause until research has actually established the validity of such applications. If in fact the construct of psychopathy does not have important predictive value, it is morally dubious to make important decisions on the basis of the diagnosis.¹⁷⁵

The PCL-R may be administered in person or based solely on records. The measurements are largely subjective. And there is no established empirical association between psychopathy and violence in a prison environment.¹⁷⁶ Despite the unreliability of this evidence, few courts find it inadmissible.¹⁷⁷

Diagnoses of mental disorders as defined in the DSM-5 have an unquantifiable influence in the context of capital case mitigation.¹⁷⁸ When a mental health expert is free to make a diagnosis of psychopath, jurors seem to accept as proven the aggravating factor of future dangerousness.¹⁷⁹ Professor Marla Sandys and colleagues determined that “mere perceptions” of future dangerousness are enough to tilt the balance in the direction of a death sentence.¹⁸⁰

¹⁷² Robert D. Hare & Craig S. Neumann, *Psychopathy: Assessment and Forensic Implications*, 54 CANADIAN J. PSYCHIATRY 791, 791–92 (2009).

¹⁷³ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 659. Note that the PCL-R method of observing and rating behavior to justify a diagnosis deserves the same criticism that Dr. Thomas Insel, former Director of the National Institute of Mental Health, noted in his blog. See Insel, *supra* note 1.

¹⁷⁴ See Don C. Fowles, Commentary, *Current Scientific Views of Psychopathy*, 12 PSYCHOL. SCI. PUB. INT. 93, 93 (2011) (discussing the radically different traditional and contemporary approaches to psychopathy).

¹⁷⁵ *Id.* at 94.

¹⁷⁶ Edens et al., *supra* note 170, at 394–95.

¹⁷⁷ See *id.* Note that in 1967, the U.S. Supreme Court found that an individual had a “psychopathic personality” that justified deportation because he was homosexual. *Boutilier v. INS*, 387 U.S. 118, 122 (1967).

¹⁷⁸ PERLIN, *supra* note 149, at 30–31.

¹⁷⁹ Edens et al., *supra* note 170, at 403.

¹⁸⁰ Marla Sandys et al., *Aggravation and Mitigation: Findings and Implications*, 37 J. PSYCHIATRY & L. 189, 189 (2009).

IV. INTELLECTUAL DISABILITY—WHERE THE DSM-5 WILL MAKE A DIFFERENCE!

Unlike sanity, competency, or mitigation, a diagnosis of intellectual disability¹⁸¹ is both a necessary and sufficient condition to invoke the Eighth Amendment's ban on cruel and unusual punishment.¹⁸² A diagnosis of intellectual disability is not exclusive of any other diagnosis, and comorbidity of other mental disorders is seen three to four times more often in those with intellectual disability than in the general population.¹⁸³

In its 2002 decision, *Atkins v. Virginia*, the U.S. Supreme Court defined intellectual disability verbatim by reference to the language of the then-current Fourth Edition of the DMS, the DSM-IV-TR, which required an IQ of seventy or below with concurrent deficits in adaptive functioning which are skills of everyday living.¹⁸⁴ There were few diagnostic details or examples in the DSM-IV-TR of deficits in functioning.¹⁸⁵ As a result, the translation of the DSM-IV-TR's clinical requirements for diagnosis of intellectual disability to the legal standards for a legal determination of intellectual disability has been the subject of hundreds of capital proceedings.¹⁸⁶

¹⁸¹ “Intellectual Disability . . . is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.” AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 33.

¹⁸² See *Hall v. Florida*, 134 S. Ct. 1986, 1992–93 (2014); *Atkins v. Virginia*, 536 U.S. 304, 318–21 (2002).

¹⁸³ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 37, 40.

¹⁸⁴ 536 U.S. at 308 n.3.

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

Id. (quoting AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 41 (4th ed., text rev. 2000) [hereinafter AM. PSYCHIATRIC ASS'N, DSM-IV-TR]). “‘Mild’ mental retardation is typically used to describe people with an IQ level of 50–55 to approximately 70.” *Id.* (quoting AM. PSYCHIATRIC ASS'N, DSM-IV-TR, *supra*, at 42–43).

¹⁸⁵ See DSM-IV-TR, *supra* note 184, at 41–49. The description of mental retardation in the DSM-IV-TR offered very little practical examples or diagnostic criteria and instead relied almost exclusively on IQ scores to define various degrees of severity of mental retardation. See *id.*

¹⁸⁶ Note that since *Atkins* in 2002, diagnostic practices for the assessment of intellectual disability have evolved. The current standards for competent assessment have incorporated

Intellectual disability has long been understood to be the result of a large number of possible causes of abnormal brain development, including fetal alcohol exposure, chromosomal abnormalities, infections during pregnancy, accidents at birth, or postnatal trauma.¹⁸⁷ Current science recognizes that in most cases of intellectual disability that have a biological cause, the affected person's IQ score falls in the range of fifty to seventy or seventy-five; however, cases exist where a person's IQ exceeds seventy-five but their daily functioning is at a level far below normal.¹⁸⁸

The DSM-5 reflects the current understanding of intellectual disability and provides diagnostic guidance that incorporates current clinical practice and experience in the diagnosis of intellectual disability. According to the DSM-5, a defendant or petitioner must, at a minimum, present evidence of the following three criteria to justify a legal finding of intellectual disability:¹⁸⁹

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
- C. Onset of intellectual and adaptive deficits during the developmental period.¹⁹⁰

scientific research and techniques agreed upon by the American Association on Intellectual and Developmental Disabilities (AAIDD) and the American Psychiatric Association. AM. ASS'N ON INTELLECTUAL & DEVELOPMENTAL DISABILITIES, INTELLECTUAL DISABILITY: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 35–40 (11th ed. 2010) [hereinafter AAIDD, INTELLECTUAL DISABILITY]; AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 37–38.

¹⁸⁷ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 38–39 (suggesting that birth defects are increased risk factors for developing intellectual disability).

¹⁸⁸ Nancy Haydt et al., *Advantages of DSM-5 in the Diagnosis of Intellectual Disability: Reduced Reliance on IQ Ceilings in Atkins (Death Penalty) Cases*, 82 UMKC L. REV. 359, 365–72 (2014).

¹⁸⁹ The U.S. Supreme Court recognized the DSM as “one of the basic texts used by psychiatrists and other experts,” and cites the DSM-5 by name thirteen times. *Hall v. Florida*, 134 S. Ct. 1986, 1990–2009 (2014). The analysis in *Hall* directly tracks the language of the DSM-5. AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 33–41.

¹⁹⁰ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 3, at 33.

The DSM-5 adopted the perspective of the American Association on Intellectual and Developmental Disabilities (AAIDD).¹⁹¹ According to the AAIDD: “[Intelligence] is not merely book learning, a narrow academic skill or test-taking smarts. Rather it reflects a broader and deeper capability for comprehending our surroundings—catching on, making sense of things, or figuring out what to do.”¹⁹² Accordingly, “[t]he various levels of severity [of intellectual disability] are defined on the basis of adaptive functioning, and not IQ scores, because it is adaptive functioning that determines the level of supports required. Moreover, IQ measures are less valid in the lower end of the IQ range.”¹⁹³

This marks a diagnostic change away from the DSM-IV-TR’s focus on IQ, and recognizes that adaptive functioning is a more comprehensive measure of the severity of intellectual disability.

The DSM-5 incorporated important psychometric guidelines for the measurement of IQ for purposes of intellectual disability assessment. For example, the DSM-5 specifies that intellectual functioning must be measured with an individually administered, psychometrically valid and current intelligence test that is normed on the general population.¹⁹⁴ IQ measurements must take into account a test’s standard error of measurement of \pm five points.¹⁹⁵ It recognizes that out-of-date test scores may be inflated due to aging test norms (known as the “Flynn Effect”).¹⁹⁶ The DSM-5 also acknowledges that a cognitive profile based on comprehensive neuropsychological testing may be more accurate than a profile based solely on a single IQ test.¹⁹⁷

The DSM-5 directs that adaptive functioning should be assessed using standardized testing as well as clinical evaluation,¹⁹⁸ and advises that educational, developmental, medical, and mental health evaluations are additional sources of

¹⁹¹ The AAIDD was formerly known as the American Association on Mental Retardation (AAMR) and is the leading professional organization for study, assessment, care, and treatment of those with intellectual disability. The DSM-IV definition of mental retardation was derived from the AAMR’s definition in AM. ASS’N ON MENTAL RETARDATION, MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 5–7 (9th ed. 1992). The DSM-5 has incorporated the language of the most recent AAIDD publication, AAIDD, INTELLECTUAL DISABILITY, *supra* note 186, at 1, 6–7. For a comparison of the AAMR and American Psychiatric Association’s historical definitions of mental retardation, see *id.* at 8–9.

¹⁹² AAIDD, INTELLECTUAL DISABILITY, *supra* note 186, at 15 (quoting Linda S. Gottfredson, Editorial, *Mainstream Science on Intelligence: An Editorial with 52 Signatories, History, and Bibliography*, 24 INTELLIGENCE 13, 13 (1997), available at <http://www.udel.edu/educ/gottfredson/reprints/1997mainstream.pdf>, archived at <http://perma.cc/U8XY-55BH>).

¹⁹³ AM. PSYCHIATRIC ASS’N, DSM-5, *supra* note 3, at 33.

¹⁹⁴ *Id.* at 37.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

evidence of intellectual disability.¹⁹⁹ Also, the DSM-5 warns that adaptive functioning in controlled environments, such as prisons and jails, may not provide a realistic perspective of a person's adaptive limitations in the community.²⁰⁰

The changes in the DSM-5 definition of intellectual disability were put to the test in *Hall v. Florida*.²⁰¹ The petitioner in *Hall* challenged the Florida Supreme Court's rule that an IQ above seventy automatically disqualified a defendant or petitioner from asserting a claim of protection from execution due to intellectual disability.²⁰² This rule was used to bar admission of any further evidence, particularly evidence of adaptive functioning, in determination of the existence of intellectual disability.²⁰³

The *Hall* opinion adopted the definition of intellectual disability directly from the DSM-5 and accepted the DSM-5's recognition of the inherent imprecision in any intelligence test measurement:

For purposes of most IQ tests, the [standard error of measurement] (SEM) means that an individual's score is best understood as a range of scores on either side of the recorded score. The SEM allows clinicians to calculate a range within which one may say an individual's true IQ score lies.²⁰⁴

The Court adopted the current professional model of intellectual disability, which recognizes adaptive functioning as a critical measure in any assessment of intellectual disability.²⁰⁵ As Justice Kennedy wisely noted, "Intellectual disability is a condition, not a number."²⁰⁶

The DSM-5 will have a significant effect in the assessment of intellectual disability for capital defendants in the following ways:

- Defendants with IQ scores in the range of seventy-one to seventy-five will not be automatically disqualified from a legal determination of intellectual disability.²⁰⁷
- The age of an IQ test is a significant consideration in the calculation of IQ score.²⁰⁸
- Any assessment of intellectual disability must consider standard error of measurement.²⁰⁹

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 38.

²⁰¹ 134 S. Ct. 1986, 1990–91 (2014).

²⁰² *Id.* at 1991–92.

²⁰³ *Id.* at 1996.

²⁰⁴ *Id.* at 1995.

²⁰⁵ *Id.* at 1994.

²⁰⁶ *Id.* at 2001.

²⁰⁷ See DSM-5, *supra* note 3, at 37.

²⁰⁸ See *id.*

²⁰⁹ See *id.*

- Recognition that limitations in adaptive functioning are critical to an assessment of intellectual disability.²¹⁰
- Recognition that records from infancy, childhood, and adolescence are valuable sources of evidence of adaptive functioning.²¹¹

Following the DSM-5 and *Hall*, Professor Edward A. Polloway published *The Death Penalty and Intellectual Disability*,²¹² which is an authoritative resource on the science that provides the basis for the definition of intellectual disability and on the critical issues involved in its diagnosis. The DSM-5, in conjunction with *The Death Penalty and Intellectual Disability*, should improve the diagnostic process of determining which capital defendants have intellectual disability and should be protected from execution.

V. CONCLUSION

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, will become a permanent fixture in criminal proceedings until the Sixth Edition supersedes it.

Changes in diagnostic classifications between the DSM-IV-TR and the DSM-5 are not likely to have a major effect on competency, sanity, or culpability assessments. The DSM-5 is likely to interject confusion among attorneys and the judiciary in sentencing and capital case proceedings. But it is unlikely that the DSM-5 will introduce significant changes to proceedings in these matters.

The DSM-5 should affect intellectual disability cases significantly by expanding the definition and understanding of, and the diagnostic procedures for, the legal determination of intellectual disability.

²¹⁰ *See id.* at 33.

²¹¹ *See id.* at 38–39.

²¹² Polloway, *supra* note 20, at 4–5, 11–15.