No. 12-10469

IN THE

Supreme Court of the United States

October Term, 2012

In re WARREN LEE HILL, JR., *Petitioner*

On Petition for Writ of Habeas Corpus In a Capital Case

BRIEF OF *AMICI CURIAE* MENTAL DISABILITY PROFESSIONALS DR. MARC TASSÉ, DR. CAROLINE EVERINGTON, DR. KAREN L. SALEKIN, DR. J. GREGORY OLLEY, DR. MARK CUNNINGHAM, DR. GILBERT MACVAUGH III, AND THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES IN SUPPORT OF THE PETITION FOR WRIT OF HABEAS CORPUS

JAMES W. ELLIS
Counsel of Record
STEVEN K. HOMER
CAROL M. SUZUKI
GEORGE BACH
ANN M. DELPHA
1117 Stanford, N.E.
Albuquerque, NM 87131
ellis@law.unm.edu
(505) 277-2146

June 10, 2013

Counsel for Amici Curiae

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

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INTEREST OF *AMICI*[1]

Amici are clinicians and scholars in the field of mental disability. As mental disability professionals, the individuals who are signatories to this brief have performed mental evaluations and diagnostic reports for courts on a variety of legal issues, but primarily evaluations of capital defendants in cases involving *Atkins v. Virginia*. They have also published many of the leading scholarly articles on the subject. The American Association on Intellectual and Developmental Disabilities (AAIDD) is a professional association in the field of mental disability, whose members are frequently called upon to provide such evaluations for the courts.

DR. MARC TASSÉ is the President of the American Association on Intellectual and Developmental Disabilities (AAIDD) and is a Professor of Psychology and Psychiatry at Ohio State University and the Director of the Nisonger Center, a University Center for Excellence in Developmental

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[1] This brief was written entirely by counsel for *amici*, as listed on the cover. No counsel for a party authored this brief in whole or in part, and neither counsel for a party nor any party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae*, the members of the organizational *amicus*, or their counsel made a monetary contribution to the preparation or submission of this brief. All parties were notified in compliance with the Rules of this Court and have given written consent to the filing of this brief. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office. James W. Ellis, counsel of record for *amici curiae*, previously served as counsel for Mr. Hill, but no longer serves in that capacity.

Disabilities. Dr. Tassé's publications include more than 85 articles in peer-reviewed journals, chapters, and books in the areas of intellectual disability and autism spectrum disorders, and he served on the AAIDD committee that wrote *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2010) [hereinafter AAIDD, *Intellectual Disability*]. Dr. Tassé has testified as an expert witness in a number of *Atkins* cases.

DR. CAROLINE EVERINGTON is an Associate Dean and Professor of Special Education at Winthrop University's Richard W. Riley College of Education in Rock Hill, South Carolina. She is also the President of the Legal Process Division of AAIDD. Dr. Everington is an expert on the evaluation of individuals with intellectual disability, and co-authored the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR), an instrument which is used by forensic evaluators throughout this country and internationally for evaluations of defendants with intellectual disability. She has also published numerous scholarly articles on assessments of individuals with intellectual disability. Dr. Everington has also served as an expert witness in several cases involving *Atkins* issues.

DR. KAREN L. SALEKIN is an Associate Professor of Psychology at the University of Alabama in the Law-Psychology concentration. Dr. Salekin, a member of the American Psychological Association's Ad Hoc Committee on Intellectual Disability and the Death Penalty, has published numerous articles on the evaluation of intellectual disability, including

articles on the potential for malingering. She has served as an expert for both the defense and the prosecution in cases involving claims under *Atkins v. Virginia*.

DR. J. GREGORY OLLEY is a Clinical Professor in the Division of Rehabilitation Counseling and Psychology, Department of Allied Health Sciences, and the Carolina Institute for Developmental Disabilities at the University of North Carolina at Chapel Hill School of Medicine. Dr. Olley is Chair of the Ad Hoc Committee on Intellectual and Developmental Disabilities of the Division on Intellectual and Developmental Disabilities of the American Psychological Association. His research interests have focused on behavior problems with persons with intellectual disability and mental illness; he has published numerous academic and clinical articles about developmental disability and has served as an expert evaluator and witness for both the prosecution and the defense in capital cases under *Atkins v. Virginia*.

DR. MARK CUNNINGHAM is a clinical and forensic psychologist, who is board certified by both the American Board of Clinical Psychology and the American Board of Forensic Psychology. Dr. Cunningham specializes in evaluations for capital sentencing, including determinations of mental retardation. Dr. Cunningham, who previously served as a Navy psychologist while serving in the U.S. Navy Reserves, has published works in the fields of forensic and clinical psychology and has served as an expert witness in numerous forensic cases. Dr. Cunningham's research and scholarship

were recognized with the 2006 American Psychological Association Award for Distinguished Contributions to Research in Public Policy.

DR. GILBERT MACVAUGH III is a forensic psychologist in private practice and specializes in conducting court-ordered forensic mental health evaluations of competency to stand trial, criminal responsibility, competence to waive *Miranda* rights, competence for execution, and intellectual disability in capital cases. He has published articles and book chapters on various forensic topics, including competency to stand trial and mental retardation and the death penalty. Along with *amicus* Dr. Mark Cunningham, Dr. Macvaugh is coauthor of one of the first scholarly articles providing forensic "practice recommendations" for *Atkins* evaluations and is a member of the AAIDD Task Force on the Death Penalty. Dr. Macvaugh has testified in numerous pretrial and post-conviction *Atkins* cases in state and federal court.

THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (AAIDD) (formerly named the American Association on Mental Retardation),[2] founded in 1876, is the nation's oldest and largest

[2] Clinicians and professionals in the field now employ the term "intellectual disability" or "ID." Robert L. Schalock et al., *The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability*, 45 Intell. & Developmental Disabilities 116 (2007). This brief refers to "mental retardation" as a synonym for intellectual disability because *Atkins* uses that term.

organization of professionals in the field of intellectual disability (mental retardation). Primarily focused on clinical, psychological, scientific, educational, and habilitative issues, AAIDD also has a longstanding interest in legal issues that affect the lives of people with intellectual disabilities. AAIDD has appeared as *amicus curiae* in this Court in a variety of cases involving mental disability, including *Atkins v. Virginia*. AAIDD has formulated the most widely accepted clinical definition of intellectual disability, as noted by this Court in *Atkins v. Virginia*, 536 U.S. 304, 308 n.3 (2002). *See* AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2010). Both as the formulator of the clinical definition of mental retardation and as an interdisciplinary membership organization vitally concerned with maintaining appropriate professional standards in the diagnosis of mental retardation, AAIDD has a strong interest in the manner in which *Atkins* claims are evaluated by the courts.

SUMMARY OF ARGUMENT

Capital defendant Warren Hill was sentenced to death after a State court determination that he did not have mental retardation. At the hearing on this issue, four expert witnesses called by the defense testified that Mr. Hill satisfied all of the elements of the clinical definition and therefore diagnosed him as having mental retardation. Three other clinicians were chosen by the government. The government's witnesses concluded that Mr. Hill did not have mental retardation because they did not

believe he had significant deficits in adaptive behavior and because they suspected that he was malingering.

All three of the government witnesses have revisited their earlier evaluations and each has now concluded that Mr. Hill does have mental retardation. The reversal by all three government witnesses, who are now in agreement with the four defense expert witnesses, is highly unusual, if not unique.

Courts have come to rely on expert witnesses when legal issues involve specialized and scientific knowledge. This has long been the case regarding questions about the mental condition of criminal defendants. Clinicians in the field of mental disability are particularly crucial in death penalty cases involving mental retardation, and the courts must be able to rely on the correctness and accuracy of the conclusions reached by expert witnesses.

Clinicians who provide expert testimony to the courts are bound by ethical codes that hold them to a high professional standard of honesty and objectivity. This standard demands that their testimony be truthful, but it also requires them to report any errors to the court, so that erroneous or misleading testimony does not lead the court to reach an incorrect legal conclusion.

The three government witnesses have acknowledged that their earlier diagnostic conclusions were wrong because of their misunderstanding about the attributes of people

with mental retardation and because of subsequent advances in the scientific understanding about intellectual disability. Their revised opinions that Mr. Hill has mental retardation are consistent with the clinical definition and the current scientific understanding in the area of intellectual disability, particularly in the areas of stereotypes about mental retardation and the potential for malingering.

As clinicians in the field of mental disabilities, *amici* are acutely conscious of the stakes in capital cases, and believe that a death sentence cannot rest upon what are now acknowledged to be diagnostic errors.

ARGUMENT

I. RELIABLE EXPERT TESTIMONY IS CRUCIAL TO ACCURATE ADJUDICATION OF *ATKINS* CLAIMS.

In adjudicating whether a capital defendant is entitled to protection from the death penalty under *Atkins v. Virginia*, 536 U.S. 304 (2002), courts must have the benefit of expert testimony from witnesses with experience in diagnosing and evaluating individuals who may have mental retardation. Reliance on such clinical expertise is particularly crucial in these cases because of the technical and psychometric issues that are essential components of the diagnostic process, and also because of the extraordinary stakes involved in getting this issue resolved accurately and correctly.

A. Accuracy in Judicial Fact-Finding Often Requires the Assistance of Witnesses from Other Professional Disciplines.

Expert witnesses from psychiatry and psychology perform an essential function in cases involving a criminal defendant's mental condition, including *Atkins* cases. "By organizing a defendant's mental history, examination results and behavior, and other information, interpreting it in light of their expertise, and then laying out their investigative and analytic process," *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985), mental disability experts permit the courts to make the most accurate determination possible about whether the individual has mental retardation.

Evidentiary rules have been fashioned to accommodate this reality and the courts' need for reliable expert evaluations. "The rules of evidence that determine the admission of expert testimony seek to ensure that expert testimony assists the judge or jury in its decision making." Daniel W. Shuman & Stuart A. Greenberg, *The Expert Witness, the Adversary System, and the Voice of Reason: Reconciling Impartiality and Advocacy*, 34 Prof. Psychology: Res. & Prac. 219, 219 (2003).

B. Courts Must Be Able to Rely on Experts to Give Them the Most Accurate and Professionally-Informed Assessments and Testimony.

Because of the nature of the clinical issues involved in an *Atkins* case, courts need to place

reliance on the evaluations and conclusions reached by expert witnesses. John Parry & Eric Y. Drogin, *Criminal Law Handbook on Psychiatric and Psychological Evidence and Testimony* 1–2 (2000) ("Judges may allow, or even solicit, experts in psychiatry and psychology to render opinions related to legal issues before the court."). *See generally* J. Gregory Olley, *Knowledge and Experience Required for Experts in Atkins Cases*, 16 Applied Neuropsychology 135 (2009). The professional expertise and experience of clinicians in the field of mental disability are crucial in *Atkins* cases, and courts must be able to rely on the experts who appear before them to provide accurate information that is consistent with the current knowledge in the field of intellectual disability.

The rules of evidence reflect the central importance of accuracy and reliability in expert testimony. For example, Federal Rule of Evidence 702 stresses the sufficiency of the facts, Fed. R. Evid. 702(b), the reliability of the expert's methodology, Fed. R. Evid. 702(c), and the reliable application of that methodology to the facts of the case, Fed. R. Evid. 702(d). Georgia law embodies the same values. *See* Georgia Code Ann. § 24-7-702(b)(1)–(3) (Supp. 2012).

In the case at bar, all three of the government's expert witnesses have determined, correctly, that they previously relied on insufficient facts, that their methodology of diagnosis was unsound, and that, as a result, they had reached an incorrect conclusion. A sentence of death cannot rest on such a flawed foundation.

II. CLINICAL EXPERTS ARE REQUIRED TO ETHICALLY AND HONESTLY INFORM THE COURTS OF THEIR CONCLUSIONS, USING THEIR BEST PROFESSIONAL JUDGMENT.

A. Psychologists, Psychiatrists, and Other Expert Clinicians Are Governed by Codes of Professional Ethics and Responsibility.

Psychologists, psychiatrists, and other clinicians operate within codes of professional responsibility and ethical guidelines, and these codes are fully consistent with the task of assisting the courts honestly. For example, the American Psychology-Law Society (a division of the American Psychological Association) provides in its *Specialty Guidelines for Forensic Psychology* that the role of forensic examiners is "to assist the trier of fact to understand evidence or determine a fact in issue, and [to] provide information that is most relevant to the psycholegal issue." Am. Psychological Ass'n, *Specialty Guidelines for Forensic Psychology*, 68 J. Am. Psychologist 7, 15 (2013) (Guideline 10.01). In performing this function for the courts, psychologists are admonished to "ensure that the products of their services, as well as their own public statements and professional reports and testimony, are communicated in ways that promote understanding and avoid deception."[3] This responsibility requires

[3] *Id.* at 16 (Guideline 11.01) ("Forensic practitioners do not, by either commission or omission, participate in misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own position or opinion.").

both integrity and candor. "When conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact." *Id.* at 9 (Guideline 1.02).

Similarly, the Ethics Guidelines of the American Academy of Psychiatry and the Law counsel caution that the adversarial nature of the legal process cannot be permitted to distort the witness's obligation to providing the court with accurate assessments and professional opinions.

> Being retained by one side in a civil or criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion. It is the responsibility of psychiatrists to minimize such hazards by acting in an honest manner and striving to reach an objective opinion.

Am. Acad. of Psychiatry & the Law, Ethics Guidelines for the Practice of Forensic Psychiatry, Guideline IV commentary (2005), *reprinted in* Philip J. Candilis et al., *Forensic Ethics and the Expert Witness* 185, 187–88 (2007).[4] *See generally* Robert

[4] This perspective is shared by the American Bar Association's *Criminal Justice Mental Health Standards*, Standard 7-1.1(b) (1988) ("In offering expert opinions and testimony concerning present scientific or clinical knowledge and in evaluating and offering expert opinions and testimony on the mental condition of criminal defendants, the mental health or mental retardation professional, no matter by whom retained, should function

Weinstock et al., *Ethical Guidelines*, in *Principles and Practice of Forensic Psychiatry* 56–72 (Richard Rosner ed., 2d ed. 2003).

All of these ethical standards share a common goal: assuring that the evaluator gives the court the most accurate and complete information available and the benefit of that professional's clinical judgment. "To achieve this goal, the psychologist assumes the role of seeker of truth and judicial educator." Shane S. Bush et al., *Ethical Practice in Forensic Psychology: A Systematic Model for Decision Making* 11 (2006).

B. The Objectivity that Ethical Standards Demand of Mental Disability Clinicians Also Requires Them to Keep an Open Mind Regarding Their Conclusions and to Communicate Any Changes to the Court.

Forensic clinical experts who evaluate defendants have responsibilities both to their profession and to the courts. "These responsibilities include being knowledgeable about the clinical and

objectively within the professional's area of expertise. . . . In evaluating the mental condition of a defendant or witness, the professional has an obligation to make a thorough assessment based on sound evaluative methods and to reach an objective opinion on each specific matter referred for evaluation."). The commentary to this standard notes that "[t]he counterpart to an attorney's responsibility to respect an evaluator's professional independence is, of course, the evaluator's obligation to perform objectively and to understand the need for objectivity." *Id.* at 10 (Commentary).

legal dimensions of the case and being forthright in testifying about their opinions, the bases of their opinions, *and any data that may undermine or contradict their position.*" Parry & Drogin, *supra*, at 48 (emphasis added). This requirement of objectivity extends beyond their initial evaluation and report.

Commitment to accuracy also means that new information and new scientific knowledge can change the professional judgments of clinical evaluators. When this occurs, the clinician is obligated to communicate with the court, so that legal judgments are not based on erroneous information.[5] The guiding principle is that clinicians are obligated to make sure that legal errors do not result from inaccuracies in the information provided to courts.[6]

[5] Even in the far shorter time period involved in evaluations for competence to stand trial, ethical standards contemplate circumstances in which the clinician may revise his or her opinion based on new information. *See* Douglas Mossman et al., *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, 35 J. Am. Acad. Psychiatry & L. at S3, S28 (Supp. 2007) (psychiatrists reserve the option "to alter an opinion should the additional materials become available.").

[6] This obligation is consistent with the requirement that psychologists act to prevent misuse of their findings. Am. Psychological Ass'n, Ethical Principles of Psychologists and Code of Conduct Standard 1.01 (2010), *reprinted in* Celia B. Fisher, *Decoding the Ethics Code: A Practical Guide for Psychologists* 340, 343 (3d ed. 2013) ("If psychologists learn of misuse or misrepresentation of their work, *they take reasonable steps* to correct or minimize the misuse or misrepresentation." (emphasis added)).

These ethical requirements on clinical evaluators apply equally when clinicians discover that their previous testimony was in error. *The Ethical Practice of Psychology in Organizations* 120 (Rodney L. Lowman ed., 1998) ("Professional integrity mandates acknowledging errors and correcting them . . . ."); Gilbert S. Macvaugh III & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 147 (2009) ("When additional error is introduced, such as through sub-optimum testing conditions or examiner mistakes in test administration or scoring, these should be candidly and proactively acknowledged."). But whether the clinician's changed understanding stems from errors in the original evaluation or from new knowledge in the field, communicating that change to the courts is required by the clinician's commitment to integrity and professional standards.

III. DETERMINING WHETHER A DEFENDANT IN A CAPITAL CASE HAS MENTAL RETARDATION REQUIRES THE EXPERTISE OF PROFESSIONAL CLINICIANS.

A. Diagnosing Mental Retardation Raises Clinical Issues that Require Skilled and Sensitive Attention from Mental Disability Professionals.

The definition of mental retardation (or intellectual disability)[7] has three prongs: (1)

[7] As noted earlier, "intellectual disability" is now the term most frequently used by clinicians in the field. *See supra* note 2.

significantly subaverage intellectual functioning; (2) deficits in adaptive skills or behavior; and (3) onset before the age of 18. AAIDD, *Intellectual Disability*, *supra*, at 5; *Atkins*, 536 U.S. at 318. The diagnosis of each of these components of the definition, and particularly the first two, requires professional expertise. The administration of appropriate intelligence tests for the first prong of the definition obviously involves substantial professional skills, and the clinically accurate and appropriate interpretation of IQ scores requires extensive experience and sophisticated understanding in the field of psychometric testing. *See generally* Alan S. Kaufman & Elizabeth O. Lichtenberger, *Assessing Adolescent and Adult Intelligence* (3d ed. 2006); AAIDD, *Intellectual Disability*, *supra*, at 35–36.

Assessment of an individual's deficits in adaptive behavior, the prong of the definition that is at issue in this case, also requires substantial professional expertise. *See generally Adaptive Behavior and Its Measurement: Implications for the Field of Mental Retardation* (Robert L. Schalock ed., 1999); Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114 (2009). "Because people with mild mental retardation typically show some adequate functioning, the emphasis is on documenting the individual's deficits, not his strengths." Olley, *supra*, at 137. Evaluators

AAIDD has made clear that the definitions associated with the two terms are identical. AAIDD, *Intellectual Disability*, *supra*, at 6.

must carefully ascertain and report whether deficits in a particular defendant's adaptive behavior are consistent with a diagnosis of mental retardation.

This task is rendered more difficult by the fact that an individual's mental retardation frequently is not obvious, either to laypersons or even to mental disability professionals with limited experience with people with intellectual disability.

> In fact, we cannot 'see' the offender with ID any more obviously than we can 'see' the offender without ID. There are no labels on their backs, and there are often no obvious signs that they are impaired enough to warrant attention. That said, underneath what appear to be typical offenders lie true differences in cognitive abilities that can dramatically affect their ability to function within the criminal justice system.

Karen L. Salekin, J. Gregory Olley & Krystal A. Hedge, *Offenders with Intellectual Disability: Characteristics, Prevalence, and Issues in Forensic Assessment*, 3 J. Mental Health Res. in Intell. Disabilities 97, 110 (2010).

B. Diagnosticians Must Be Alert to the Dangers Posed by Stereotypes About People with Intellectual Disability.

Evaluators—as well as courts—must be cautious that their conclusions are not based on stereotypes about people with mental retardation.

Much of our nation's mistreatment of people with intellectual disability, and particularly the eugenics era in our history, can be traced to false stereotypes about the nature of the disability. *See generally* James W. Trent, Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* 131–224 (1994); *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 454 (1985) (Stevens, J., concurring) ("[T]he mentally retarded have been subjected to a history of unfair and often grotesque mistreatment." (internal citation omitted)).

The most problematic aspect of such stereotyping involves assumptions, often unstated (and frequently unrecognized), that individuals with mental retardation are essentially identical to one another and that no one with that disability would be able to perform a particular task that might seem incongruent or inconsistent with the diagnosis. *See* AAIDD, *User's Guide: Intellectual Disability: Definition, Classification, and Systems of Supports* 25–26 (2012) [hereinafter AAIDD, *User's Guide*]. All individuals with mental retardation have both strengths and weaknesses. AAIDD, *Intellectual Disability*, *supra*, at 45. "These strengths may confound a layperson or a professional with limited clinical experience with individuals who have mild mental retardation." Tassé, *supra*, at 121.[8] This, in

[8] *See also* Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intell. & Developmental Disabilities 220, 220 (2009) ("[A]ll individuals with intellectual disability typically demonstrate strengths in functioning along with relative limitations.").

turn, can mislead the observer to "erroneously interpret these pockets of strengths and skills as inconsistent with mental retardation because of their misconceptions regarding what someone with mental retardation can or cannot do." *Id.*

While forensic evaluators are likely to have a much fuller understanding of mental disability generally than that possessed by laypersons, even the knowledge of some forensic experts about mental retardation may be incomplete. "Often, experts who are involved in death penalty cases are not familiar with the most recent definitional perspectives. This situation is often combined with some very stereotyped and inaccurate notions of the characteristics of persons with mental retardation." Caroline Everington & J. Gregory Olley, *Implications of Atkins v. Virginia: Issues in Defining and Diagnosing Mental Retardation*, 8 J. Forensic Psychology Prac. 1, 5 (2008); *see* Macvaugh & Cunningham, *supra*, at 142 ("[Individuals] with mild mental retardation who become involved in the criminal justice system typically do not exhibit stereotypical physical or behavioral characteristics commonly associated with severe mental retardation. As a result, they are often misperceived as having a 'normal' appearance."); *see also* Snell & Luckasson et al., *supra* note 8, at 220 ("Most of these individuals are physically indistinguishable from the general population . . . ."). False stereotypes about mental retardation, therefore, can contribute to misdiagnosis.

C. Concerns About the Potential for Malingering Should Be Evaluated Cautiously.

One of the potential challenges in evaluating an *Atkins* defendant is the possibility that the individual is feigning symptoms in order to be (falsely) identified as having mental retardation. Although clinicians in the field of mental disability have long recognized and studied the potential for false claims of *mental illness*,[9] the question of potential malingering of *mental retardation* has only been studied in recent years. *See* Karen L. Salekin & Bridget M. Doane, *Malingering Intellectual Disability: The Value of Available Measures and Methods*, 16 Applied Neuropsychology 105, 106 (2009). It is now clear that these two different forms of mental impairment are quite dissimilar with regard to their susceptibility to any attempted malingering.

First, as a practical matter, feigning mental retardation would prove quite complex. AAIDD, *User's Guide*, *supra*, at 24 (The requirements for a diagnosis of mental retardation must have been present from an early age, "so there is almost always a documented lifetime history . . . of significant limitations in intellectual functioning and adaptive behavior."). "[M]alingering requires a degree of

[9] *See, e.g.*, Sanford L. Drob & Robert H. Berger, *The Determination of Malingering: A Comprehensive Clinical-Forensic Approach*, 15 J. Psychiatry & L. 519 (1987) (discussing techniques for detecting the imitation of the classic signs and symptoms of mental illness).

sophistication that would be difficult for someone with a very low IQ." Olley, *supra*, at 138. See also Everington & Olley, *supra*, at 18 ("Multiple sources of information, including performance on current and previous standardized tests, should be carefully considered before concluding that the individual is malingering. Malingering should not be concluded based solely on one source—performance on one test or an observation in one setting.").

Second, although it is contrary to the interests of capital defendants, individuals with mental retardation share a strong desire to *mask* their disability, and to attempt to appear to be smarter and more capable than they are in fact. *See generally* AAIDD, *User's Guide*, *supra*, at 24 ("[T]he more common faking direction when an individual with ID attempts to fake is to 'fake good' so as to hide their ID and try to convince others that he or she is more competent."). This phenomenon has been repeatedly noted by scholars, *e.g.*, Robert B. Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (1967), and observed by clinicians who work with individuals who have mental retardation. "Individuals with intellectual disability may go to great lengths to hide their limitations, consuming significant effort to attempt to appear as their often-mistaken image of competent." Snell & Luckasson et al., *supra* note 8, at 226. This compulsion to appear more capable continues even when identification of the disability would be advantageous to the individual. *See generally id.* at 225. Failure to recognize these efforts and take them into account can lead to misdiagnosis. "Basing a diagnostic finding on first

impression is additionally problematic, as persons with mental retardation often attempt to compensate for their limitations through behaviors that mask their disability." Macvaugh & Cunningham, *supra*, at 142.

IV. THE THREE GOVERNMENT EVALUATORS IN THIS CASE APPROPRIATELY AND PROFESSIONALLY CORRECTED THE ERRORS THEY DISCOVERED IN THEIR EARLIER REPORTS TO THE STATE HABEAS CORPUS COURT.

In the case at bar, three expert witnesses, Thomas H. Sachy, M.D., Donald W. Harris, Ph.D., and James Gary Carter, M.D., were selected by the Attorney General's office to evaluate the defendant to help determine whether he had mental retardation. Each testified that Mr. Hill did not have mental retardation. All three witnesses have now reviewed and reconsidered their evaluations and, remarkably, all three have now concluded that Mr. Hill has mental retardation.

Dr. Thomas Sachy, a psychiatrist whose primary experience was in the area of mental illness, particularly brain injuries and seizure disorders in patients with Alzheimer's disease, evaluated Mr. Hill in December 2000. Sachy Aff. ¶¶ 3, 4, Feb. 8, 2013. His report and testimony at that time concluded that Mr. Hill did not have mental retardation. *Id.* at ¶¶ 7, 18. Dr. Sachy assumed that acquisition of a driver's license, holding a job, and having relationships with women were inconsistent with a

diagnosis of mental retardation. *Id.* at ¶ 17. He also believed that Mr. Hill's adaptive behavior deficits were the result of malingering. *Id.* at ¶ 7.

In the summer of 2012, Dr. Sachy read press accounts about recent developments in the case and, in light of his fuller knowledge about mental retardation and his clinical experience over the intervening twelve years, decided to review his earlier findings. *Id.* at ¶¶ 5, 8. Although he had had very little clinical contact with individuals with mental retardation in 2000, in the intervening years he gained substantial experience with people who had intellectual disability, *Id.* at ¶¶ 3, 8, and recognized that his earlier conclusions had been incorrect. *Id.* at ¶¶ 6, 9, 18. Based on that experience, and based on advances in the clinical understanding of mental retardation, he concluded that Mr. Hill had not been malingering, and that his previous conclusion that individuals with mental retardation could not have served in the Navy or have held a job were incorrect, and based on inaccurate stereotypes. *Id.* at ¶¶ 7, 15–16. He now concludes that Mr. Hill meets the definition of mental retardation. *Id.* at ¶¶ 6, 18.

Upon learning of Dr. Sachy's reevaluation of his 2000 opinion in this case, Dr. Donald Harris reviewed his own participation in the case. At the time of the original evaluation, Dr. Harris had been a psychologist at Georgia's Central State Hospital. Harris Aff. ¶ 4, Feb. 11, 2013. Based in large part on "advances in the understanding of mental retardation," *id.* at ¶ 21, he now concludes that he previously misread and misinterpreted Mr. Hill's

responses as evidence of malingering, *id.* at ¶¶ 8, 16, and that fuller understanding of the nature of mental retardation has led him to conclude that Hill's Navy service was not inconsistent with a diagnosis of mental retardation. *Id.* at ¶¶ 12–14. He now believes "to a reasonable degree of scientific certainty, that Mr. Hill does meet the criteria" for mental retardation. *Id.* at ¶ 22.

Dr. James Carter, the third government evaluator from the proceedings in 2000, learned of Dr. Sachy's and Dr. Harris's reconsideration of their diagnoses, and reviewed his own conclusions from the earlier mental retardation hearing. Dr. Carter had been a clinical psychiatrist at Central State Hospital. Carter Aff. ¶ 2, Feb. 12, 2013. Upon reconsideration following a review of the evidence, particularly related to malingering and the evidence of adaptive behavior, including Mr. Hill's school records, *id.* at ¶¶ 10–11, Dr. Carter agrees with Dr. Sachy and Dr. Harris that Mr. Hill meets the definitional criteria of mental retardation. *Id.* at ¶ 7.

Each of these three evaluators has now concluded that Mr. Hill has mental retardation. Their reevaluation is based on their experience with mental retardation and on developing knowledge about the condition in the field of intellectual disability. There is now agreement among the three expert witnesses selected by the state and the four expert witnesses called by the defense that Mr. Hill has mental retardation.

V. CLINICIANS RECOGNIZE THAT *ATKINS* CASES REQUIRE THE HIGHEST DEGREE OF CONFIDENCE AND ACCURACY IN DETERMINING WHETHER A CAPITAL DEFENDANT HAS MENTAL RETARDATION.

Expert witnesses and evaluators must always perform their duties with a high degree of professionalism and clinical accuracy in any case before any court. But, as in so many ways, a death penalty case is different. "Ethical considerations are central to any forensic mental health assessment, but they take on increased salience in the context of death penalty cases." David DeMatteo et al., *Forensic Mental Health Assessments in Death Penalty Cases* 145 (2011) (internal citations omitted); *see also* Mossman et al., *supra* note 6, at S22–S23 ("Evaluating a defendant in a case in which the prosecution plans to seek the death penalty raises additional concerns regarding ethical behavior for court-appointed, defense-retained, and prosecution-retained psychiatrists.").

Clinicians in the field of intellectual disability clearly recognize that capital cases require the highest level of diagnostic accuracy and professional confidence. "Any case involving a diagnosis of mental retardation should be considered as 'high stakes,' and, as such, clinicians should always use the utmost prudence and rigor in conducting these diagnostic evaluations. Nonetheless, no one can deny that an 'Atkins claim' is the highest of high stakes." Tassé, *supra*, at 116–17. "For successful implementation of *Atkins*, it is crucial that the

evaluation and diagnosis of mental retardation are consistent with professional standards of practice. Certainly, there is no assessment situation where the stakes are higher." Everington & Olley, *supra*, at 4–5 (internal citations omitted).[10]

Revision of clinical judgments by expert witnesses such as the ones at issue in this case is certainly rare, if not unique. The reconsideration and reversal of their previous erroneous conclusions by these three experts is laudable. Further, their decisions to revisit the evidence in this case in light of advances in the scientific understanding of mental retardation and their own clinical experience exemplify the highest ethical standards of their professions. Their revised conclusions are fully consistent with the scientific consensus about the nature of mental retardation and the process of clinical evaluations under *Atkins*.

The three government witnesses in this case who have now re-evaluated the evidence, and who have now concluded that the defendant *does* have mental retardation, have demonstrated the commitment to accuracy and professionalism that courts should value most from professional experts.

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[10] *See also* Mark D. Cunningham & Marc J. Tassé, *Looking to Science Rather Than Convention in Adjusting IQ Scores When Death Is at Issue*, 41 Prof. Psychology: Res. & Prac. 413, 415 (2010) ("It is not that 'mental retardation' is defined differently in a capital context. Rather, historical testing is likely to take a greater role in *Atkins* cases, and the importance of 'getting it right' is of graver magnitude when death is at issue." (internal citation omitted)).

With the potential consequences for a capital defendant from a misdiagnosis at this most elevated level, the door cannot be closed to more accurate factfinding and clinical interpretation by the government's own clinical experts.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to grant Mr. Hill's petition for an original writ of habeas corpus, or to transfer it to the District Court for evidentiary proceedings.

Respectfully submitted,

JAMES W. ELLIS
Counsel of Record
STEVEN K. HOMER
CAROL M. SUZUKI
GEORGE BACH
ANN M. DELPHA
1117 Stanford, N.E.
Albuquerque, NM 87131
ellis@law.unm.edu
(505) 277-2146

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Counsel for Amici Curiae