IN THE SUPREME COURT OF THE STATE OF ARIZONA

STATE OF ARIZONA, Petitioner, vs. THE HONORABLE SILVIA R. ARELLANO, Judge of the Superior Court, in and for the County of Pinal, Respondent, AND MICHAEL APELT and RUDI APELT, Real Parties in Interest.	Arizona Supreme Court Case No.: CV-05-0397-SA Pinal County Superior Court Case No.: CR-14946

BRIEF OF AMICI CURIAE
AMERICAN ASSOCIATION ON MENTAL RETARDATION,
THE ARC OF THE UNITED STATES, AND THE ARC OF ARIZONA

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INTEREST OF AMICI CURIAE

The American Association on Mental Retardation, The Arc of the United States, and The Arc of Arizona, amici curiae, are national professional and voluntary organizations in the field of mental retardation.

The American Association on Mental Retardation (AAMR) (formerly the American Association on Mental Deficiency), founded in 1876, is the nation's oldest and largest interdisciplinary organization in the field of mental retardation. The AAMR is an internationally-recognized researcher and educator on the diagnosis and support of individuals with cognitive disabilities. Among its most important professional activities is the production and periodic updating of a manual of terminology and classification for use by clinical experts in the field.[1] Currently in its tenth edition, this manual provides the primary definition of mental retardation. Its commentary presents the current consensus and is the most authoritative analysis of the application of that definition and source of professional guidance for the evaluation of individuals who may have mental retardation. *See* AAMR, *Mental Retardation* (10th ed. 2002).

The Arc of the United States (formerly the Association for Retarded Citizens of the United States), through its approximately 900 state and local

[1] Other organizations, such as the American Psychiatric Association, have followed the AAMR's lead with similar definitions in their manuals.

chapters, including **The Arc of Arizona**, is the largest voluntary organization in the United States devoted solely to the welfare of the more than seven million children and adults who have mental retardation and their families.

Amici have long been assisting legislators and judges in shaping public policy and legal protections for people with mental retardation. Through their state and local chapters, they have actively participated in the formulation of legislation in Arizona and other states concerning defendants with mental retardation. *See* J. Ellis, *Disability Advocacy and the Death Penalty*, 33 N.M. L. Rev. 173 (2003). They also have participated as amici curiae before the United States Supreme Court concerning this issue. *E.g.*, Brief of Amici Curiae AAMR, The Arc of the United States, et al., *Atkins v. Virginia*, 536 U.S. 304 (2002). Amici have been actively involved in assisting legislatures and courts in the implementation of the Supreme Court's *Atkins* decision. *E.g.*, Brief of Amici Curiae AAMR and The Arc of the United States, *In re Hawthorne*, 105 P.3d 552 (Cal. 2005).

INTRODUCTION

Clinical experts are regularly called upon to perform assessments of defendants who may have mental retardation. They do so by applying the generally accepted definition of mental retardation using standardized tests and their experience and judgment. Rather than address whether Michael and Rudi Apelt have mental retardation, an issue of fact disputed by the parties and their

respective expert witnesses, amici focus on the accepted definition of mental retardation, its proper application through the exercise of clinical judgment by qualified experts in the field, and relevant implications for judicial management of *Atkins* hearings such as the one at issue in this special action. Amici hope this proves helpful to the Court in its task of providing guidance to lower courts that have the initial responsibility of fact-finding and accurately assessing the merits of individual *Atkins* claims brought by capital defendants in Arizona.

ARGUMENT

I. THE GENERALLY ACCEPTED CLINICAL DEFINITION OF MENTAL RETARDATION HAS THREE ESSENTIAL ELEMENTS.

In *Atkins v. Virginia*, 536 U.S. 304 (2002), the United States Supreme Court held that the Eighth Amendment prohibits the execution of any individual who has "mental retardation." The Court left to the states, in the first instance, "the task of developing appropriate ways to enforce the constitutional restriction upon [their] execution of sentences." *Id.* at 317. This "task" necessarily requires legislatures and courts to consider, in the first instance, how to define the condition known as "mental retardation." *See id.* at 317 n.22.

The definition of mental retardation has been revised from time to time as researchers and clinicians have developed a greater understanding of the condition. Amici have been at the forefront of this evolution through their efforts to refine the diagnosis and support individuals with mental retardation. The AAMR has

updated its definition of mental retardation ten times since 1908 to remain current with new information or breakthroughs in clinical and scientific research. The definition of mental retardation has been consistent since 1992.

Although the Supreme Court in *Atkins* did not prescribe any particular approach to effectuate its decision, it did recognize the AAMR's 1992 definition of mental retardation as authoritative:

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

Id. at 309 n.3 (quoting AAMR, *Mental Retardation* (9th ed. 1992)). The three elements of the 1992 definition -- (i) intellectual functioning, (ii) adaptive skills, and (iii) age of onset -- have been and remain primary considerations in clinical assessments by clinical experts in the mental retardation field.

In 2001, the Arizona legislature largely adopted the AAMR's 1992 definition of mental retardation, then the most current definition available, for purposes of pre-conviction proceedings after the effective date of the statute. *See State v. Dann*, 206 Ariz. 371, 375 n.3, 79 P.3d 58, 62 n.3 (2003) (discussing legislative history); Ariz. Rev. Stat. Ann. § 13-703.02(K)(2) (West Supp. 2005) ("'Mental retardation' means a condition based on a mental deficit that involves significantly

subaverage general intellectual functioning, existing concurrently with significant impairment in adaptive behavior, where the onset of the foregoing conditions occurred before the defendant reached the age of eighteen."). In response to *Atkins*, the Arizona legislature amended Section 13-703.02 to apply to all capital sentencing proceedings. *See State v. Dann*, 206 Ariz. at 375 n.3, 79 P.3d at 62 n.3 (citing Ariz. Rev. Stat. Ann. § 13-703.02(J)).

The AAMR subsequently refined its definition of mental retardation to reflect a decade of significant developments in the field and current scientific consensus. AAMR, *Mental Retardation* (10th ed. 2002). The 2002 edition of *Mental Retardation* maintains the three essential elements embodied in both Section 13-703.02(K)(2) and the 1992 edition, and further elaborates five critical assumptions necessary for proper application of the definition:

> **MENTAL RETARDATION:**
>
> Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.
>
> The following five assumptions are essential to the application of this definition:
>
> 1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.

2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.

3. Within an individual, limitations often coexist with strengths.

4. An important purpose of describing limitations is to develop a profile of needed supports.

5. With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve.

AAMR, *Mental Retardation* 1 (10th ed. 2002).

Numerous federal appellate and state supreme courts around the country since have adopted the AAMR's 2002 definition when considering claims of mental retardation. *See, e.g., In Re Hawthorne*, 105 P.3d 552, 556-57 (Cal. 2005); *Pruitt v. State*, 834 N.E.2d 90, 107 (Ind. 2005); *State v. Harris*, 859 A.2d 364, 446 (N.J. 2004); *State v. Dunn*, 831 So. 2d 862, 881 (La. 2002); *In re Hearn*, 418 F.3d 444, 445 (5th Cir. 2005). Likewise, the superior court applied the AAMR's 2002 definition for purposes of deciding pretrial motions in the proceedings below.[2] Order at 5-6 n.3, *State v. Apelt*, No. CR 14946 (Ariz. Super. Ct. Pinal County July 21, 2005) (order on parties' pre-hearing evidentiary motions).

[2] The State's proffered expert cites the 2002 edition of *Mental Retardation* as an authoritative source for his report. (App. to Rudi Apelt's Resp. to Pet. for Special Action, Ex. H at 2-3 (Report of John A. Moran, Ph.D.) (Dec. 16, 2005)).

The AAMR's 2002 definition reflects current scientific consensus in the mental retardation field and it explains the proper application of the definition set forth in Section 13-703.02(K)(2). Amici therefore respectfully submit the Court should recognize the AAMR's 2002 definition in the context of *Atkins* proceedings such as this one to ensure that Section 13-703.02 is applied in a manner consistent with current scientific consensus in the mental retardation field. *Cf. State v. Grell*, 205 Ariz. 57, 64, 66 P.3d 1234, 1241 (2003) ("The trial court should use *Atkins* as a guide and should, insofar as is practical in the post-trial posture of this case, follow the procedures established in A.R.S. section 13-703.02.")

We now turn to the three essential elements of the definition of mental retardation.

A. Significant Limitations In Intellectual Functioning

A clinical assessment of whether a defendant has mental retardation typically begins with a measurement of any impairment of intellectual (or cognitive) functioning. The degree of impairment necessary to satisfy the first element of the mental retardation definition is "significantly subaverage general intellectual functioning." Ariz. Rev. Stat. Ann. § 13-703.02(K)(2). This term of art has a specific clinical meaning in the mental retardation field. For decades, the term "significantly subaverage" has been used by clinical experts to describe the level of impairment found in individuals whose performance on standardized

intelligence (or IQ) tests places them two standard deviations below the mean (i.e., the lowest two and a half or three percent of the population). AAMR, *Mental Retardation* 14 (10th ed. 2002).[3] Individuals who score in this range have substantial cognitive impairment.

As the Supreme Court recognized in *Atkins*, "[n]ot all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus." 536 U.S. at 317. Some claims for Eighth Amendment protection will fail because the defendant's intellectual functioning is not "significantly subaverage." Although mental retardation professionals diagnose the presence or absence of "significantly subaverage general intellectual functioning" using intelligence tests, it is not possible to identify a "fixed cutoff point for making the diagnosis of mental retardation." AAMR, *Mental Retardation* 58 (10th ed. 2002).

Clinical standards offer guidance for establishing which defendants satisfy the intellectual functioning element of the mental retardation definition. In terms of numerical measurements, two standard deviations below the mean has been identified as "an IQ standard score of approximately 70 to 75 or below, based on assessment that includes one or more individually administered general

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[3] *See also* AAMR, *Mental Retardation* 5 (9th ed. 1992); American Association on Mental Deficiency, *Classification in Mental Retardation* 11 (8th ed. 1983).

intelligence tests developed for the purpose of assessing intellectual functioning." AAMR, *Mental Retardation* 5 (9th ed. 1992); *accord* AAMR, *Mental Retardation* 14, 58 (10th ed. 2002). The Arizona legislature likewise defined "significantly subaverage" intellectual functioning as "a full scale intelligence quotient of seventy or lower," but required that courts "shall take into account the margin of error for the test administered." Ariz. Rev. Stat. Ann. § 13-703.02(K)(4). The margin of error is significant, because it is possible to diagnose mental retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, mental retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. *See* AAMR, *Mental Retardation* 57, 80 (10th ed. 2002).[4]

The particular circumstances of an individual's testing, the differences among IQ instruments, and the attendant margin of error, mean the upper boundary of mental retardation can never be fixed at a precise IQ score. "The assessment of intellectual functioning through the primary reliance on intelligence tests is fraught with the potential for misuse if consideration is not given to possible errors in measurement. An obtained IQ standard score must always be considered in terms of the accuracy of its measurement." AAMR, *Mental Retardation* 57 (10th ed.

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[4] *Accord* American Psychiatric Ass'n ("APA"), *Diagnostic and Statistical Manual of Mental Disorders* 41-42 (4th ed. text revision 2000).

2002). One reason for this is relatively minor differences among IQ instruments, including their scoring methodology. An "important source of possible variation lies in test content differences across different scales and between different age levels on the same scale. ... Variations also may be attributed to differences in the standardization samples, to changes between different editions of the same scale, to shifts to an alternative scale as an individual's chronological age increases, and to variances in the person's abilities or performance." AAMR, *Mental Retardation* 59 (10th ed. 2002).[5] Courts should be careful to ensure, therefore, that each IQ score has been "validated with additional test scores or evaluative information." AAMR, *Mental Retardation* 5 (9th ed. 1992).

The determination of whether an individual has significantly subaverage general intellectual functioning is not indeterminate or unmanageable, nor is the boundary of mental retardation subject to manipulation. Although this issue does not admit of a rigid rule involving a single, one-size-fits-all IQ score, experienced clinicians in the field of mental retardation bring their experience and judgment to the task and reach an individualized determination regarding a particular defendant. In cases in which clinical experts disagree on the extent of a

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[5] *Accord* American Psychological Ass'n, *Manual of Diagnosis and Professional Practice in Mental Retardation* 27 (Jacobson & Mulick eds. 1996) ("Each intelligence or cognitive measure will differ in the clarity with which its structure permits isolation of specific cognitive functions.").

defendant's cognitive impairment, trial courts are able to weigh the evidence supporting their differing opinions. As in any case involving disputed expert testimony, courts will be able to reach a judgment about whether the defendant's intellectual limitation falls within statutory and constitutional protections.

Clinical experience over the last two decades has shown that, although IQ scores are a good indicator of mental retardation, they are just the beginning of a mental retardation assessment. The degree of intellectual impairment must be considered along with adaptive behavior skills. AAMR, *Mental Retardation* 58, 80 (10th ed. 2002). A valid assessment of mental retardation therefore requires careful assessment of individual factors, and cannot be reduced to a single inflexible rule about IQ scores. *Id.* at 58.

B. Significant Limitations In Adaptive Behavior

Low IQ scores, standing alone, are not a sufficient basis upon which to diagnose mental retardation unless the disability also manifests significant limitations on the individual's ability to function in the world. Accordingly, a clinical "[d]iagnosis should include a balanced consideration of assessments of IQ and adaptive behavior." AAMR, *Mental Retardation* 80 (10th ed. 2002).

1. Adaptive Behavior Exists on a Spectrum of Skill Areas.

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

AAMR, *Mental Retardation* 73 (10th ed. 2002). Conceptual skill areas include language, reading and writing, money concepts, and self-direction. Social skills include interpersonal skills, personal responsibility, self-esteem, gullibility, naiveté, and the ability to follow rules and obey laws. Practical skills include activities of daily living, occupational skills, and the ability to maintain safe environments. AAMR, *Mental Retardation* 73 (10th ed. 2002);[6] *accord* Ariz. Rev. Stat. Ann. § 13-703.02(K)(1) ("'Adaptive behavior' means the effectiveness or degree to which the defendant meets the standards of personal independence and social responsibility expected of the defendant's age and cultural group."). Clinical experts in the field of mental retardation are trained to evaluate observations of strengths and limitations in these skill areas.

"Within an individual, limitations often coexist with strengths. This means that people with mental retardation are complex human beings who likely have

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[6] Previously, the AAMR's 1992 edition of *Mental Retardation* specified ten adaptive skill areas: "communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work." AAMR, *Mental Retardation* 5 (9th ed. 1992). "The requirement [in the 1992 edition] that significant limitations be present in at least 2 of the 10 skill areas was particularly problematic when the 10 areas were not known to be internally consistent or independent." AAMR, *Mental Retardation* 81 (10th ed. 2002). In 2002, the AAMR reconsidered and changed this component of the definition criteria based on evolving scientific consensus. *Id.* Many of the aforementioned ten adaptive skill areas continue to be relevant considerations in mental retardation assessments today, however, clinicians now are less focused on whether deficits exist in two of them, and instead evaluate them on a spectrum in terms of conceptual, social, and practical skills. *Id.* at 81-82.

certain gifts as well as limitations. Like all people, they often do some things better than other things. Individuals may have capabilities and strengths that are independent of their mental retardation. These may include strengths in social or physical capabilities, strengths in some adaptive skill areas, or strengths in one aspect of an adaptive skill in which they otherwise show an overall limitation." AAMR, *Mental Retardation* 8 (10th ed. 2002). The existence of such strengths does not preclude a diagnosis of mental retardation if all of the requirements of the definition are satisfied. *Id.* This is true even if such strengths do not reflect common stereotypes among non-experts of what a person with mental retardation can do. It is essential that trained mental retardation professionals apply clinical judgment to evaluate the spectrum of an individual's adaptive skills and limitations. *Id.* at 85.

2. Limitations in Adaptive Behavior Are Measurable.

Significant limitations in adaptive behavior are "established through the use of standardized measures normed on the general population, including people with disabilities and people without disabilities. On these standardized measures, significant limitations in adaptive behavior are operationally defined as performance that is at least two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical, or (b) an overall score on a standardized measure of conceptual, social,

and practical skills." AAMR, *Mental Retardation* 76 (10th ed. 2002). If an individual scores at least two standard deviations below the mean in one area of adaptive behavior (conceptual, social, or practical), and functions in the average or above-average range in the other two areas, "clinical judgment should be used to determine whether the deficit is limited to one area of adaptive behavior and is not due to mental retardation." *Id.* at 78.

The requirement that cognitive impairment be accompanied by limitations in adaptive skills serves an important function in the *Atkins* context by assuring clinicians (and courts) that a mental retardation diagnosis is not merely an anomaly that is the product of poor test-taking ability or malingering. "Malingering" means consciously attempting to feign the disability of mental retardation for personal gain. *See* BLACK'S LAW DICTIONARY 970 (7th ed. 1999). In the *Atkins* context, the government frequently argues that low IQ scores or evidence of adaptive skill deficits should be disregarded as unreliable because the defendant has a motive to malinger. (*See, e.g.*, State's Pet. for Special Action, at 20-21 (Nov. 23, 2005) (arguing "Defendants motives for malingering")). This argument and its underlying assumptions are not consistent with amici's clinical experience for several reasons.

Defendants with mental retardation frequently exhibit an intense motivation to conceal their disability and appear stronger and more able than they actually are

in fact. J. Ellis & R. Luckasson, *Symposium on the ABA Criminal Justice Mental Health Standards: Mentally Retarded Criminal Defendants*, 53 Geo. Wash. L. Rev. 414, 430-31 (1985). Accordingly, malingering is not a commonly encountered problem in assessing mental retardation. Even if the Court were to accept the State's bare assertion -- that capital defendants claiming mental retardation have a motive to malinger during a clinical assessment to avoid execution -- the presence of an asserted *motive* to malinger is not helpful to distinguish capital defendants who have mental retardation from those who do not have the disability. Trained mental retardation professionals can evaluate whether or not an individual is, *in fact*, malingering, through the application of their experience, clinical judgment, and evaluation of various standardized tests.

3. Adaptive Behavior Must Be Evaluated in the Context of Typical Environments.

Trained clinical experts in the field of mental retardation must consider limitations in adaptive functioning in the context of typical environments. An individual's functional abilities must be measured against the standards that prevail in typical community-based environments, such as homes, schools, businesses, or other environments in which people ordinarily work, live, play, and interact. AAMR, *Mental Retardation* 8, 78 (10th ed. 2002). A valid assessment of mental retardation also must take into account cultural or linguistic factors that may influence the results. *Id.* at 8. Observations of behavior in atypical environments

(such as prison), or in a single environment, usually do not provide an accurate view of adaptive functioning. *Id.* at 78. When a defendant is incarcerated and cannot be observed in typical community-based environments, clinical experts must apply their experience and judgment to available information about the defendant's adaptive skills in typical environments prior to confinement. *Id.* at 94.

C. Manifestation Before The Age Of Eighteen

Once it has been determined that a capital defendant has significantly subaverage general intellectual functioning and concurrent deficits in adaptive behavior, the only remaining inquiry is whether the disability manifested itself before the age of eighteen. The requirement that the disability manifested before the age of eighteen does not mean that it necessarily was diagnosed at that age. In many cases, there is no record of a formal assessment or IQ test being administered during the individual's childhood. A childhood manifestation nevertheless may be identified through evidence of adaptive skill deficits, such as repeated failure to meet developmental milestones during early childhood, performance at school, and other youth activities. Records from schools, doctors, and social service agencies may illuminate this issue.[7] In other cases, the most persuasive evidence may come

[7] There are many reasons, however, why a specific diagnosis of mental retardation may not be found in school or other records for the defendant before the age of eighteen, such as the reluctance of schools (and parents) to assign a diagnosis of

(continued...)

from neighbors, relatives, teachers, and others who may have observed circumstances indicating disability or developmental problems in childhood.

In practice, very few cases turn on the issue of age of onset. Almost every person with the requisite level of intellectual impairment and adaptive behavior deficit has had the disability since birth or childhood.[8] Amici believe that courts should not create rigid rules of evidence based on this element of the definition. *See also infra*, n.13.

II. RELIANCE ON THE CLINICAL JUDGMENT OF TRAINED MENTAL RETARDATION EXPERTS PROMOTES ACCURATE AND JUST ASSESSMENTS OF *ATKINS* CLAIMS.

Under Arizona law, criminal defendants cannot receive the ultimate sanction if they have mental retardation. Ariz. Rev. Stat. Ann. § 13-703.02(A). This elevates the question of whether a defendant has mental retardation to a life or death issue. *Atkins* further elevated the question to one of constitutional

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mental retardation when other labels that are more socially acceptable (e.g., learning disability) can earn a student the right to receive the same services.

[8] The only exceptions would be persons whose mental disability first occurred during adulthood, whether as a result of traumatic brain injury, dementia resulting from physical illness, or the like. Such individuals (who do not appear to be numerous in the caseload of the criminal courts) do not have mental retardation within the meaning of the clinical definition. Their disabilities, however, may raise equal protection concerns and might appropriately be considered in the context of an actual case involving such a defendant, should one arise.

importance. Courts have recognized, however, that making an accurate judicial assessment of mental retardation claims is not a simple task:

> The diagnosis and evaluation of mentally retarded defendants is not a simple task. ... There is more to evaluating a mentally retarded defendant than merely giving an I.Q. test. Systematic assessment requires the thoughtful selection and administration of valid examination instruments together with careful observation, interviewing, and analysis of all the data by a professional with proper training and experience.

E.g., *State v. Bricker*, 581 A.2d 9, 16 (Md. 1990) (internal quotation omitted).

Arizona law recognizes the need for clinical expertise and assigns "psychological experts" a prominent and essential role in criminal proceedings where a judicial assessment of mental retardation is required.[9] *See* Ariz. Rev. Stat.

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[9] Other states similarly require expert testimony in *Atkins* hearings. *E.g.*, *State v. Dunn*, 831 So. 2d 862, 887 (La. 2002) (remanding for *Atkins* hearing "during which the court will be guided by evaluation and diagnosis made by those with expertise in diagnosing mental retardation."); *Wiley v. State*, 890 So. 2d 892, 895 (Miss. 2004) (Mississippi law requires *Atkins* claimant to submit expert testimony that he or she has mental retardation under AAMR or APA definitions); *see also Ake v. Oklahoma*, 470 U.S. 68, 82 (1985) (indigent defendant entitled to assistance of psychiatrist because, "without the assistance of a psychiatrist to conduct a professional examination on issues relevant to the defense, to help determine whether the insanity defense is viable, to present testimony, and to assist in preparing the cross-examination of a State's psychiatric witnesses, the risk of an inaccurate resolution of sanity issues is extremely high. With such assistance, the defendant is fairly able to present at least enough information to the jury, in a meaningful manner, as to permit it to make a sensible determination."); *Williams v. Dretke*, Civ. Action No. H-04-2945, 2005 U.S. Dist. LEXIS 34438, at *18-*19 (S.D. Tex. July 15, 2005) (providing "funding for expert assistance" to inmate with colorable *Atkins* claim); *Morris v. State*, CR-02-1765, 2005 Ala. Crim. App.

(continued...)

Ann. § 13-703.02(B) (requiring court to appoint prescreening psychological expert when Arizona notices its intent to seek death penalty); *id.* § 13-703.02(D) (requiring court to and establishing procedures to appoint additional psychological experts if the prescreening expert determines the defendant's intelligence quotient is sufficiently low); *id.* § 13-703.02(E) (requiring submission of opinions by experts appointed to examine defendant for mental retardation). Arizona law further requires that "psychological experts" have appropriate licenses and "at least two years' experience in the testing, evaluation and diagnosis of mental retardation." *Id.* § 13-703.02(K)(3). Accordingly, experienced clinicians and their assessments should be afforded substantial deference when courts make judicial assessments of whether defendants have mental retardation.

A. Properly Trained Clinicians Provide the Most Reliable Evidence for a Judicial Determination of Someone's Mental Retardation.

Proper application of the definition of mental retardation requires a complex scientific analysis of cognitive ability, adaptive functioning, and personal history. No element of the definition predominates, and isolated observations of non-experts have limited value. The evaluation should be undertaken by a qualified

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LEXIS 235, at *55-*62, 2005 WL 3118817, at *19-*22 (Ala. Crim. App. Nov. 23, 2005) (trial court's refusal to provide defendant funds for mental health expert violated due process because expert necessary during the penalty phase of the trial, in light of *Atkins*).

clinical expert, not only with the training and experience necessary to understand the elements of the definition of mental retardation, but also with the "clinical judgment" to evaluate the cognitive and behavioral characteristics that may lead to a diagnosis of mental retardation.

"Clinical judgment" is "a special kind of judgment rooted in a high level of clinical expertise and experience" that is necessary to observe, analyze, and evaluate an individual's cognitive abilities and adaptive behaviors. AAMR, *Mental Retardation* 95 (10th ed. 2002); R. Schalock & R. Luckasson, *Clinical Judgment* vii (AAMR 2005). "These characteristics of clinical judgment separate it from intuition, blind faith, or professional license." *Id.* Thus, "when making decisions and demonstrating best practices, clinicians use more than research-based knowledge, professional standards, and professional ethics." *Id.*

The three elements that comprise the AAMR definition of mental retardation are the starting point for an evaluation, but clinical judgment is the lens through which an individual's cognitive abilities and adaptive behaviors must be viewed to make a valid mental retardation assessment. The application of clinical judgment is crucial because the definition of mental retardation requires a multi-faceted

scientific analysis of an individual's cognitive abilities and adaptive skills and deficits observed in a variety of typical environments.[10]

Clinical experts typically measure cognitive ability and adaptive behavior by administering objective tests and scales.[11] Clinical judgment is essential to the selection of appropriate tests, the proper use of those tests, and the correct interpretation of test results, in light of the particular characteristics of the defendant to be evaluated. *See* AAMR, *Mental Retardation* 83 (10th ed. 2002). Relevant characteristics include the defendant's physical and mental health, environment, cultural background, and age. *Id.* at 85.

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[10] The issue of mental retardation is fundamentally different from the issue of competency to stand trial. When a defendant's competency to stand trial is at issue, trial courts can use common sense and their own observations (along with expert opinions) to assess whether the defendant can assist in his or her own defense. In contrast, mental retardation is not susceptible to evaluation by non-experts, and the disability only can be assessed through scientific tests administered by experienced professionals in the field using their training, experience, and clinical judgment.

[11] Intellectual functioning is assessed by administering one or more standardized intelligence tests (IQ tests) that measure intelligence across a number of factors, including verbal ability, quantitative reasoning, visual reasoning and memory. *See* AAMR, *Mental Retardation* 59-64 (10th ed. 2002). Adaptive skills are measured across three key domains of adaptive behavior: conceptual skills, social skills and practical skills. *Id.* at 73, 76. Within these broad skill areas are more specific skills such as communications skills (conceptual skills), interpersonal skills and self-esteem (social skills) and activities of daily living and occupational skills (practical skills). *Id.* at 82. Numerous instruments exist for measuring adaptive skills. Commentators, in fact, have identified over 200 such measures. *Id.* at 87.

Using clinical judgment, trained clinical experts also compile and evaluate a detailed history of the defendant's adaptive skills and deficits across a spectrum of typical environments. This history is based on available academic, medical or other records, and interviews of the defendant and non-experts who have observed the defendant. Clinical judgment is the reason lay observation can assist a clinical professional in informing his judgment about an individual's adaptive deficits or skills, even though the same observation, standing alone, has little probative value. Clinical judgment allows complex, sometimes seemingly contradictory information to be put in the proper perspective to determine if an individual has mental retardation.

B. The Dangers of Non-Expert Testimony Concerning Mental Retardation

Non-expert witnesses who lack the necessary clinical background in mental retardation are just as likely to confuse the trier of fact as to assist it. Despite the fact that mental retardation is a permanent condition, isolated adaptive skills and deficits can change over time through life experience and learning, or by virtue of personalized supports. Non-expert observations of isolated adaptive behaviors are of minimal probative value. The non-expert lacks an understanding of the continuum of skills and deficits that an individual may exhibit across different aspects of everyday life. Non-expert recollections about a defendant's adaptive behavior also may be inaccurate or biased. Non-experts frequently have limited

opportunities to observe the defendant, or have multiple observations of the defendant in a single setting, which are of limited value.

An expert clinician, on the other hand, understands that "[l]imitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture." AAMR, *Mental Retardation* 8 (10th ed. 2002). Expert analysis of observations across multiple environments and time periods, and the application of clinical judgment, filters potential inaccuracies and biases of non-experts and leads to a more complete and accurate picture of the defendant's adaptive skills and deficits. In a recent case, the experts disregarded non-expert observations altogether based on their professional judgment and the circumstances of the particular case:

> While it is true that [the experts] did not conduct such interviews [of people who observed the defendant's behavior in prison facilities], it is patently untrue that no "independent testing" was conducted. [One expert] testified that he administered two tests of adaptive functioning, the ILS test and the Adaptive Behavior Systems Assessment, and that the tests revealed that [the defendant] suffered from significant deficits in adaptive behavior on both tests. Furthermore, [the experts] both explained the reasons they did not interview third-party sources. [One expert] testified that, in his professional experience, he has not found third-party interviews to be very helpful, particularly in view of the fact that [the defendant] had been in prison for 20 years.

Tarver v. State, CR-00-2267, __ So.2d __, 2005 Ala. Crim. App. LEXIS 240, at *27, 2005 WL 3118789, at *8 (Ala. Crim. App. Nov. 23, 2005) (Cobb, J., concurring in part and dissenting in part).

The problems presented by non-expert testimony have great relevance to *Atkins* hearings, because the defendant's current environment -- usually a corrections facility -- is both one-dimensional and atypical. Prisons are highly structured environments in which inmates have little autonomy, little interaction with others, little emotional or behavioral support, few personal responsibilities, and significant free time. Accordingly, the adaptive skills and deficits observed in prison are not probative of adaptive skills in a typical environment, and are not relevant to an expert in making a valid clinical assessment.[12]

C. Non-Expert Evidence in *Atkins* Hearings Should Be Limited.

The parties in this case are litigating novel questions concerning the admissibility of testimony by non-expert witnesses in the context of an *Atkins* hearing. Amici take no position concerning the admissibility of specific testimony by witnesses designated by the parties. As a general matter, however, courts are more likely to assess an individual's mental retardation accurately if they rely on evidence provided by properly-trained experts. Reliance on non-expert opinions

[12] A defendant's adaptation to the highly regimented conditions of prison is not the same as developing adaptive skills in a typical environment. Adaptive skills observed in prison are not probative of adaptive skills in a typical environment.

and evidence should be carefully circumscribed and should not be given greater weight than afforded by clinical experts in the mental retardation field.

Clinical experts routinely interview people who came into contact with a defendant to gain a better understanding of the defendant's adaptive skills or deficits. Non-expert observations, however, should be evaluated by an expert in the context of an overall analysis, rather than being credited with independent or potentially undue significance.

The superior court carefully circumscribed certain non-expert testimony in this case. The superior court precluded direct testimony from ADOC employees who observed the defendants' adaptive behavior in prison, but the superior court did not appear to exclude such evidence to the extent that an expert might rely upon it as support for an opinion.[13] The superior court's overall approach to non-expert testimony affords appropriate deference to the clinical judgment and central role of experts in *Atkins* proceedings, and should be applied to other non-expert

[13] The superior court's decision to preclude direct testimony of ADOC employees appears to have been based, at least in part, on their lack of experience with the defendants prior to the age of eighteen. A decision to exclude non-expert evidence solely on this basis would not be consistent with clinical practice. Trained experts in mental retardation regularly consider non-expert observations of post-eighteen adaptive behavior to be relevant to an assessment of mental retardation. Those non-expert observations, however, receive little or no weight from clinical experts if they are made in the context of atypical environments (such as prison), or in the context of a single environment. (*See supra*, Argument § I.B.3). The potential for confusion among trial courts concerning non-expert evidence in *Atkins* proceedings highlights the need for appropriate guidance from this Court.

evidence as well. Limiting direct evidence from non-experts in this manner promotes accuracy in judicial assessments of mental retardation claims.

III. MENTAL RETARDATION EXPERTS MUST BE FAMILIAR WITH THE CULTURE AND LANGUAGE OF THE DEFENDANT.

A "[v]alid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors." AAMR, *Mental Retardation* 8 (10th ed. 2002). A defendant's "culture or ethnicity, including language spoken at home, nonverbal communication, and customs that might influence assessment results, must be considered in making a valid assessment." *Id.* If the expert is unable to understand a defendant because of cultural or linguistic differences, it substantially reduces the reliability of the clinical assessment. Therefore, it is generally accepted in the mental retardation field that psychological experts must be capable of understanding a defendant's cultural background and be able to communicate with the defendant in the defendant's first language.

The defendants in this case are German nationals. Any proffered expert witness in mental retardation should be able to speak German and have an understanding of the defendants' cultural backgrounds. An expert lacking these qualifications, but otherwise meeting the standards in Section 13-703.02(K)(3), would still raise serious questions about the reliability and admissibility of their opinions.

The parties appear to have recognized the importance of culture and language in making an accurate assessment when they initially retained experts in this case. Rudi Apelt and the State initially hired German psychologists to assess Rudi's mental retardation claim. (*See* Rudi Apelt's Resp. to Pet. for Special Action, at 2-3 (Dec. 16, 2005)). The State nevertheless argues that it is not bound by its original expert's opinion, and has hired a new expert, John A. Moran, Ph.D. (*See* State's Pet. for Special Action, at 21 (Nov. 23, 2005); Appx. to Rudi Apelt's Resp. to Pet. for Special Action, Ex. H at 2-3 (Report of John A. Moran, Ph.D.) (Dec. 16, 2005)). It is unclear, however, whether Dr. Moran speaks German or is familiar with German culture. The parties undoubtedly will have to litigate this issue in further proceedings on remand, and the issue is likely to recur in many *Atkins* proceedings because Arizona is a diverse state, further heightening the importance of the Court's guidance in this special action.

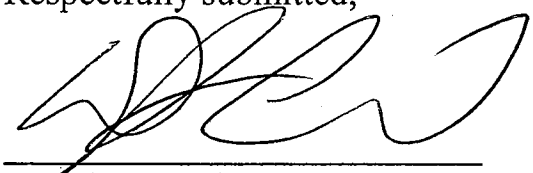
To promote accurate judicial assessments of mental retardation, the Court should provide guidance to trial courts that, to the extent practicable, clinical experts in the field of mental retardation should be culturally and linguistically apposite to the defendant. At a minimum, however, to meet the generally accepted standards of reliability in the mental retardation field, clinical experts must consider, and therefore be familiar with, the culture and language of the defendant in making a valid assessment.

CONCLUSION

Atkins and Section 13-703.02 reflect the constitutional and public policy judgments that the death penalty should never be imposed on an individual who has mental retardation. Guaranteeing the faithful implementation of those principles will require trial courts to conduct careful fact-finding with the assistance of knowledgeable and experienced mental retardation professionals employing expert clinical judgment.

Dated: February 27, 2006

Respectfully submitted,



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CERTIFICATE OF COMPLIANCE

Pursuant to ARIZ. R. P. SPECIAL ACTIONS 7(f) and ARIZ. R. CIV. APP. P. 14(b), 16(a), I certify that:

1. This brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14 point Times New Roman font.

2. This brief contains 6,449 words including footnotes, less than the 12,000 word limit for an amicus curiae brief. Consistent with ARIZ. R. CIV. APP. P. 14(b), the total of 6,449 words excludes the table of contents, table of authorities, and all certificates of counsel attached to this brief. I have relied on the word count function of Microsoft Word in making this certification.

Dated: February 27, 2006

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CERTIFICATE OF SERVICE

I hereby certify that I caused true and correct copies of the foregoing brief to be served on February 27, 2006 upon the following in the manner indicated:

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