No. 00-8727

IN THE
Supreme Court of the United States

ERNEST PAUL McCARVER,
Petitioner,

v.

STATE OF NORTH CAROLINA,
Respondent.

On Writ of Certiorari to the
Supreme Court of North Carolina

BRIEF OF AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AND THE AMERICAN ACADEMY OF PSYCHIATRY AND LAW AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

The American Psychological Association is a voluntary, nonprofit, scientific and professional organization that was founded in 1892. With more than 155,000 members and affiliates, it is the major association of psychologists in the United States. Among the Association's major purposes is to increase and disseminate knowledge regarding human behavior, and to foster the application of psychological learning to important human concerns. The Association's Division of Mental Retardation and Developmental Disabilities endeavors to advance the treatment of mental retardation and developmental disabilities, based on scientific inquiry and high standards of practice. The Association has filed briefs for this Court's consideration in similar cases, including *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999); *Penry v. Lynaugh*, 492 U.S. 302 (1989); *Ford v. Wainwright*, 477 U.S. 399 (1986); and *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985).

The American Psychiatric Association, with more than 40,000 members, is the Nation's largest organization of physicians specializing in psychiatry. It has participated in numerous cases in the Court. *See, e.g.*, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999); *Riggins v. Nevada*, 504 U.S. 127 (1992); *Estelle v. Smith*, 451 U.S. 454 (1981).

The American Academy of Psychiatry and the Law, with approximately 2,500 members worldwide, is an organization of psychiatrists dedicated to excellence in practice, teaching, and research in forensic psychiatry.

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[1] Petitioner and respondent have filed with the Court blanket consents to the filing of amicus briefs in support of either party. No party authored this brief in whole or in part and no one, other than Amici, their members, or their counsel contributed to the preparation or submission of this brief.

Issues at the heart of this case – namely, mental retardation and its diagnosis – have been the subject of significant research by psychologists and psychiatrists. Thus, Amici submit this brief to present relevant scientific knowledge that provides a context for the Court's review of whether the Constitution prohibits the execution of individuals with mental retardation.

SUMMARY OF ARGUMENT

Due to their disability, individuals with mental retardation cannot attain the very high level of personal culpability or blameworthiness that they must have to be punishable by death. Mental retardation is a developmental disability defined by significant impairments in intellectual functioning – impairments that also significantly limit the individual's ability to cope with everyday tasks required to care for one's self and interact in society (called "adaptive functioning"). Although many individuals with mental retardation can achieve comparative independence when they receive appropriate training, support, and services, the fact remains that such persons are *substantially* less capable of both abstract reasoning and practical or adaptive functioning than non-retarded adults. These very real and serious impairments are reflected in diminished capacities to understand basic facts, foresee the moral consequences of actions, learn from one's mistakes, and grasp the feelings, thoughts, and reactions of other people.

A comparison with children is useful here. Adults with mental retardation are, of course, *not* children. Nonetheless, with respect to personal culpability, adults with mental retardation and children share the critical characteristics of diminished capacity to understand the moral and factual consequences of their actions, to control their impulses, and to make independent decisions without undue influence by others.

Accordingly, a categorical prohibition against execution of members of both groups is warranted. Just as that categorical prohibition is not rendered inappropriate by the wide variation in the intellectual and practical abilities of children up to the age of 15, it is also not inappropriate merely because mental retardation varies in severity and in the practical abilities it affects. Indeed, unlike 15-year-olds, *all* individuals with mental retardation exhibit *substantially* more limited intellectual and practical functioning than the typical adult.

A blanket prohibition against the execution of individuals with mental retardation is workable, because mental retardation can be identified using time-tested instruments and protocols with proven validity and reliability. Incorrect diagnoses are forestalled because mental retardation may be diagnosed only if three necessary criteria are all present: significant limitations in intellectual functioning, significant limitations in practical or "adaptive" functioning, and onset before adulthood. Qualified professionals who conduct a complete mental retardation examination of an individual will be able to make an objective determination whether the individual has mental retardation, in the sense that independent professionals undertaking separate assessments should reach the same conclusion.

To achieve objectivity, however, certain safeguards must be followed. The assessment must be performed by qualified professionals with experience relating to mental retardation and to administration of IQ and adaptive functioning tests. The evaluation must also be complete, *i.e.*, it must include a thorough assessment of each of the three necessary criteria indicating mental retardation. Compliance with these safeguards should curtail unnecessary legal wrangling, conflicting "diagnoses," and both false positive and false negative determinations concerning whether the individual has

mental retardation. Proper clinical procedures are essential where, as here, life or death is at issue.

ARGUMENT

I. Due To Their Disability, Individuals With Mental Retardation Cannot Attain The Very High Level Of Blameworthiness Required For Capital Punishment.

Individuals with mental retardation are incapable of attaining the very high level of moral culpability or blameworthiness that is required before an individual may be singled out to be punished by death. "Under the Eighth Amendment, the death penalty has been treated differently from all other punishments." *Thompson v. Oklahoma*, 487 U.S. 815, 856 (1988) (O'Connor, J., concurring in judgment). The decision to impose the death penalty must "be directly related to the personal culpability of the criminal defendant." *Penry v. Lynaugh*, 492 U.S. 302, 319 (1989); *see also Thompson*, 487 U.S. at 834 (plurality) (same). Therefore, the decision to punish a crime with death "'requires a nexus between the punishment imposed and the defendant's blameworthiness.'" *Thompson*, 487 U.S. at 853 (O'Connor, J., concurring in judgment) (quoting *Enmund v. Florida*, 458 U.S. 782, 825 (1982) (O'Connor, J., dissenting)); ***see also Stanford v. Kentucky*, 492 U.S. 361, 382 (1989) (O'Connor, J., concurring in judgment).**

Mental retardation significantly diminishes an offender's blameworthiness. Mental retardation is universally defined as (1) significant limitations in general intellectual functioning, (2) which exist concurrently with significant limitations in adaptive functioning, (3) the onset of which begins before adulthood. *See* Editorial Board, *Definition of Mental Retardation* [hereinafter *Definition*], *in Manual of Diagnosis*

and Professional Practice in Mental Retardation 13, 13 (John W. Jacobson & James A. Mulick eds., American Psychological Association 1996) [hereinafter *APA Manual*]; American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992) [hereinafter *AAMR Manual*]; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 41 (4th ed. text revision 2000) [hereinafter *DSM-IV-TR*]. These three defining criteria – all of which must be present before an individual may be classified as having mental retardation, *see Definition*, at 14; *see also AAMR Manual*, at 5; *DSM-IV-TR*, at 41 – are interrelated in a way that diminishes blameworthiness.

As the definition of mental retardation makes clear, it is not marked simply by limitations in intellectual functioning or by limitations in adaptive functioning. Rather, "[t]he limitations in adaptive skills are . . . closely related to the intellectual limitation." *AAMR Manual*, at 6; *see also id.* at 14-15 ("the intellectual limitations must have an impact on coping or adaptive skills to meet the definition"); *Definition*, at 22. Thus, people with mental retardation have intellectual limitations that result in real and serious impairments in "how effectively individuals cope with common life demands." *DSM-IV-TR*, at 42; *see also Definition*, at 20 (mental retardation is characterized by "poor generalization skills and motivational deficits [as well as] deficits in major problem-solving processes and practical knowledge or skills").[2] Further, mental retardation is a developmental disability, which means

[2] Specifically, diagnosis of mental retardation requires serious limitations in at least two of these adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. *See AAMR Manual*, at 5; *Definition*, at 30-31; *DSM-IV-TR*, at 41.

that these serious intellectual and adaptive limitations manifest themselves before the individual achieves the ability to function as an adult. *See AAMR Manual*, at 16-18; *Definition*, at 36-37; *DSM-IV-TR*, at 47.

Of course, people with mental retardation display a range of intellectual and adaptive abilities. Individuals with mental retardation may possess relative strengths in some skills areas, especially compared to their limitations in others (*e.g.*, an adult who cannot learn to read might have some limited math skills). *See, e.g.*, *AAMR Manual*, at 6-7. With supports and services tailored to their individual needs, persons with mental retardation can also generally continue to improve in their functioning over time. *See, e.g.*, *id.* at 7. Indeed, with the appropriate support, supervision, and assistance, some individuals with mental retardation can learn to live independently and/or hold menial jobs. *See, e.g.*, *DSM-IV-TR*, at 43.[3]

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[3] Because individuals with mental retardation have varying skills and thus varying needs for support, the American Association on Mental Retardation uses a subclassification system that reflects the level and kind of

Despite these individual variations, the very definition of mental retardation means that all persons with this disability suffer from very substantial impairments in their intellectual

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support needed. *See AAMR Manual*, at 26, 34. Alternatively, people with mental retardation are sometimes subclassified as having either "mild," "moderate," "severe," or "profound" mental retardation, depending on the degree of their intellectual and adaptive functioning. *See Definition*, at 14-19; *DSM-IV-TR*, at 43-44. Note that the term "mild" mental retardation can be misleading, for even the highest functioning individuals with mental retardation must have substantial cognitive and behavioral disabilities before they can be diagnosed with retardation. *See Definition*, at 13 (mental retardation requires *significant* limitations in intellectual and adaptive functioning); *AAMR Manual*, at 5 (same); *DSM-IV-TR*, at 41 (same).

and adaptive abilities compared to non-retarded individuals. Although there is no precise census of the number of people with mental retardation, studies invariably put the number at less than 3% of the general population, usually in the 1% to 3% range. *See, e.g.*, D.D. Smith & Ruth Luckasson, *Introduction to Special Education: Teaching in an Age of Challenge* 146 (2d ed. 1995).

This small group represents those whose intellectual limitations substantially restrict their development and adaptive functioning. These limitations are reflected in diminished capacities to understand and process facts and information;[4] to learn from mistakes and from experience generally;[5] to generalize and to engage in logical if-then reasoning;[6] to control impulses;[7] to communicate;[8] to understand the moral

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[4] *See* John J. McGee & Frank J. Menolascino, *The Evaluation of Defendants with Mental Retardation in the Criminal Justice System, in The Criminal Justice System and Mental Retardation* 55, 58-59 (Ronald W. Conley et al. eds., 1992); Diane Courselle et al., *Suspects, Defendants, and Offenders with Mental Retardation in Wyoming*, 1 Wyo. L. Rev. 1, 24 (2001); James W. Ellis & Ruth A. Luckasson, *Mentally Retarded Criminal Defendants*, 53 Geo. Wash. L. Rev. 414, 431 (1985).

[5] *See* McGee & Menolascino, *supra*, at 58; Kenneth L. Appelbaum & Paul S. Appelbaum, *Criminal-Justice-Related Competencies in Defendants with Mental Retardation*, J. of Psychiatry & L. 483, 488 (Winter 1994).

[6] *See* McGee & Menolascino, *supra*, at 58, 60; Appelbaum & Appelbaum, *supra*, at 488.

[7] *See* McGee & Menolascino, *supra*, at 58; Appelbaum & Appelbaum, *supra*, at 489; Ellis & Luckasson, *supra*, at 429.

[8] *See* Appelbaum & Appelbaum, *supra*, at 487; Ellis & Luckasson, *supra*, at 428; *see also* Solomon M. Fulero & Caroline Everington, *Assessing Competency to Waive* Miranda *Rights in Defendants with Mental Retardation*, 19 L. & Human Behavior 533, 535 (1995).

implications of actions and to engage in moral reasoning;[9] and to recognize and understand the feelings, thoughts, and reactions of other people.[10] Moreover, people with mental retardation are often especially eager to please others, a characteristic obviously susceptible to manipulation.[11]

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[9] *See* Margaret C. Flynn et al., *The Mentally Handicapped Adult's Concepts of Good and Bad Acts*, 29 J. Mental Deficiency Research 55, 61-62 (1985); McGee & Menolascino, *supra*, at 59-60; Appelbaum & Appelbaum, *supra*, at 489; Yael Isrealy, *The Moral Development of Mentally Retarded Children: Review of the Literature*, 14 J. of Moral Educ. 33 (1985); Ellis & Luckasson, *supra*, at 429-30.

[10] *See* Tom Gumpel, *Social Competence and Social Skills Training for Persons with Mental Retardation*, 29 Educ. & Training in Mental Retardation & Developmental Disabilities 194 (1994); McGee & Menolascino, *supra*, 59-60; Appelbaum & Appelbaum, at 489.

[11] *See* Caroline Everington & Solomon M. Fulero, *Competence to Confess: Measuring Understanding and Suggestibility of Defendants with Mental Retardation*, 37 Mental Retardation 212, 212-13 (1999); Fulero &

These serious limitations necessarily diminish the personal culpability or blameworthiness of individuals with mental retardation. This is not to say that such individuals are never competent to stand trial or that they should not be held responsible for their actions. But the death penalty is imposed only on a small subset of all persons convicted of crimes, and its imposition must reflect the greater personal blameworthiness of those who are executed compared to those who are not so punished. *See supra* at 4. Every individual with mental retardation has impaired cognitive and practical functioning that reduces his or her personal blameworthiness relative to others who commit similar crimes.

A comparison with children is instructive. The Eighth Amendment bars execution of individuals who were under the age of 16 at the time they committed their crimes. *See Thompson*, 487 U.S. at 838 (plurality); *id.* at 857-58 (O'Connor, J., concurring in judgment where legislature has not specifically authorized such executions). Of course, adults with mental retardation are different in many important respects from children; accordingly, the two groups should and do have different legal rights and responsibilities. *See, e.g.*, *Penry*, 492 U.S. at 339-40 (opinion of O'Connor, J.).

Everington, *supra*, at 535; Ellis & Luckasson, *supra*, at 431-32.

Nonetheless, with respect to the potential blameworthiness that can attach to their actions, children and persons with mental retardation share the same critical characteristic: diminished intellectual and practical capacities compared to non-retarded adults. The constitutional bar and national consensus against execution of juvenile offenders reflects the fact that "inexperience, less education, and less intelligence make the teenager less able to evaluate the consequences of his or her conduct while at the same time he or she is much more apt to be motivated by mere emotion or peer pressure than is an adult." *Thompson*, 487 U.S. at 835 (plurality). The very same considerations apply to a person with mental retardation. *See, e.g.*, *Penry*, 492 U.S. at 322 (opinion of Court) ("Because Penry was mentally retarded, [he was] less able than a normal adult to control his impulses or to evaluate the consequences of his conduct . . ."). *See also supra* at 7-8 (describing impairments typical of individuals with mental retardation).

The bar against execution of juvenile offenders also illustrates the principle that disproportionality between the death penalty and an individual's personal culpability can sometimes be found for an entire class of persons, rather than case by case. Juveniles range widely in their intellectual and practical abilities, both between and within age groups. Yet, no one may be executed for a crime committed below the age of 16 due to the diminished blameworthiness that attaches to persons in that class.

Indeed, a particular 15-year-old may possess very strong reasoning skills commensurate with most adults. In contrast, by definition *every* individual with mental retardation has much more limited reasoning skills. And while an adult with mental retardation may have more years' life experience than a juvenile, that additional experience has little bearing on blameworthiness due to the limited ability of persons with

mental retardation to use information from one situation to help guide behavior in another. Perhaps most importantly, a case-by-case determination of the blameworthiness of individuals with mental retardation is especially inappropriate because mental retardation – unlike youth – may be treated by sentencers as an aggravating rather than a mitigating factor, resulting in imposition of the death penalty based on the very condition that makes the individual less blameworthy than a non-retarded offender. *See Penry*, 492 U.S. at 323.[12]

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[12] Psychological research also indicates that capital sentencing juries are frequently incapable of understanding sentencing instructions, which diminishes the likelihood that case-by-case capital sentencing will properly

reflect the reduced blameworthiness of individuals with mental retardation. *See* Richard L. Wiener et al., *The Role of Declarative and Procedural Knowledge in Capital Murder Sentencing*, 28 J. Applied Soc. Psychology 124 (1998); Craig Haney & Mona Lynch, *Clarifying Life and Death Matters: An Analysis of Instructional Comprehension and Penalty Phase Closing Arguments*, 21 L. & Human Behavior 575 (1997); Richard L. Wiener et al., *Comprehensibility of Approved Jury Instructions in Capital Murder Cases*, 80 J. Applied Psychology 455 (1995).

Comparison with juveniles is also useful for the light it sheds on the problem of line-drawing. In *Thompson*, all members of the Court agreed that the Constitution bars execution of juveniles below *some* age. *See* 487 U.S. at 828-29 (plurality); *id.* at 848 (O'Connor, J., concurring in judgment); *id.* at 872 (Scalia, J., dissenting). Yet, because development from childhood to adulthood is a continuous process, it presents the question of where on the developmental spectrum to draw the line between constitutionally permissible and impermissible executions. *See id.* at 838 (plurality) (declining to decide whether death penalty may be imposed on juveniles 16 or older when they commit a crime); *id.* at 854 (O'Connor, J., concurring in judgment) (recognizing line-drawing problem); *id.* at 872 (Scalia, J., dissenting) ("there is no clear line here").

Mental retardation does not present a similar line-drawing problem. As explained above, professionals in the area of mental disabilities have developed criteria of mental retardation that apply only to those whose developmental limitations in intellectual functioning are also reflected in substantial limitations in adaptive functioning, *i.e.*, the ability to cope with and solve the practical and social problems faced by independent adults. Although individuals with "borderline intellectual functioning" may have IQ scores almost as low as (or even equal to) some individuals with mental retardation, these two groups are clearly differentiated, because only among persons with mental retardation is the deficit in intellectual functioning also associated with a substantial impairment of adaptive functioning. *See, e.g.*, *DSM-IV-TR*, at 41-42, 48, 740.

Thus, individuals with mental retardation form a well-demarcated group that is defined by precisely those characteristics that are relevant to their diminished blameworthiness: developmentally rooted deficits in both intellectual and adaptive functioning that are substantially

below the level of other adults. Accordingly, individuals with mental retardation necessarily lack the very high level of blameworthiness that is required before a person can be punished by death.

II. Objective Diagnosis Of Mental Retardation Can Be Made By Qualified Practitioners Using Proven Measurement Instruments.

A determination that persons with mental retardation may not be executed raises questions concerning whether and how such persons can be reliably identified. The clinical knowledge of psychologists, psychiatrists, and other professionals relating to the diagnosis of mental retardation is highly relevant to these issues. As we explain below, mental retardation is a disability that can be identified using well established, valid, and reliable tests and procedures (Part A). In order to avoid incorrect diagnoses, however, it is essential that the evaluation be performed by professionals who are qualified in the area of mental retardation and who perform a complete mental retardation evaluation (Part B).

A. Mental Retardation Can Be Identified Through the Use of Time-Tested and Scientifically Grounded Assessment Instruments and Protocols.

Psychologists and other mental retardation professionals have developed tests and other evaluative tools that allow the identification of individuals with mental retardation. Two qualified mental retardation professionals separately administering these diagnostic tests should reach the same conclusion concerning whether an individual has mental retardation. As a result, a blanket rule against execution of persons with mental retardation should *not* result in new "battles of experts" concerning whether a defendant, in fact, has mental retardation. We elaborate this point below with reference to the three definitional criteria of mental retardation: significant limitations in intellectual functioning, significant limitations in adaptive functioning, and onset before adulthood.

1. *Intellectual Functioning*. The first criterion of mental retardation is the existence of significant limitations in general intellectual functioning. *See Definition*, at 13; *AAMR Manual*, at 5; *DSM-IV-TR*, at 41. In this context, "significant limitations" means two or more standard deviations below the mean. *See Definition*, at 13; *AAMR Manual*, at 35; *DSM-IV-TR*, at 41.[13]

[13] Standard deviation is a statistical measure of the variability in the distribution of events. Only about 2.3% of individuals should have true IQ scores two or more standard deviations below the mean. *See AAMR Manual*, at 37.

Tests that measure cognitive functioning have been used since the beginning of the twentieth century to classify individuals' cognitive abilities and to diagnose mental retardation and similar disabilities. *See* Donald K. Routh, *Intellectual Development, in APA Manual*, at 85, 87-88. Today, standardized IQ tests are the presumptive instruments of measurement among professionals that diagnose and treat mental retardation. *AAMR Manual*, at 36.[14] Individually

[14] Standardized IQ tests cannot be used in some situations, such as when persons are observed in cultural settings different from their home countries. *See id.* at 35. In such situations, "the general guideline for consideration of intellectual functioning performance as determined by clinical judgment is that it must be below the level attained by approximately 97 percent of persons of comparable age and cultural backgrounds." *Id.* at 35-36.

administered IQ tests are widely recognized as *valid* and *reliable* means of assessing intellectual functioning for the purpose of diagnosing mental retardation. *See id.* at 35 (IQ tests are "only way to address the intellectual aspect of mental retardation in a normative way").[15] Clinicians confirm the

[15] "Validity" and "reliability" have technical meanings in connection with standardized tests. "Validity refers to the degree to which evidence and theory support the interpretations of test scores entailed by proposed uses of tests," American Educational Research Association, American Psychological Association & National Council on Measurement in Education, *Standards for Educational and Psychological Testing* 9 (1999) – colloquially, that the test measures what it is being used to measure. "*Reliability* refers to the consistency of [test] measurements when the testing

results of IQ tests by evaluating the individual's functioning in everyday settings and roles. *See id.* at 36.

On the scales used by many IQ tests, two standard deviations below the mean corresponds to a true score of 70. *See, e.g.*, *Definition*, at 14 (table); *DSM-IV-TR*, at 41. However, "there is a measurement error of approximately 5 points in assessing IQ." *DSM-IV-TR*, at 41. Hence, an individual who scores 75 on a standardized IQ test may in fact suffer from the intellectual limitations that constitute the first necessary criterion for a diagnosis of mental retardation. *See id.* Accordingly, all authorities agree that an individual with an IQ of 75 may be diagnosed with mental retardation – *but only if significant limitations in adaptive functioning also exist*. *See Definition*, at 15; *AAMR Manual*, at 14-15; *DSM-IV-TR*, at 41-42. This is one reason why adaptive limitations have been embraced by mental retardation professionals as an integral part of the definition of mental retardation.

2. *Adaptive Functioning*. The second necessary criterion of mental retardation is the existence of significant limitations in adaptive functioning. *See Definition*, at 13; *AAMR Manual*,

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procedure is repeated on a population of individuals or groups." *Id.* at 25. As explained below in the main text, standard IQ tests have standard errors of about 5 points, which is a reflection of their comparative reliability.

at 5; *DSM-IV-TR*, at 41. "[A]daptive behavior refers to what people do to take care of themselves and to relate to others in daily living rather than the abstract potential implied by intelligence." *AAMR Manual*, at 38; *see also DSM-IV-TR*, at 42 ("*Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting").

As explained above, mental retardation is a developmental disability that affects such everyday functioning in addition to the conceptual intelligence measured by IQ tests. Thus, although an IQ score between 70 and 75 is not a dispositive indication of mental retardation, comprehensive evaluation of adaptive functioning skills by a qualified mental retardation professional should be sufficient to resolve any question concerning whether the subject has mental retardation. *See, e.g.*, *AAMR Manual*, at 15. An adaptive functioning evaluation is therefore critical for a sound diagnosis of mental retardation. *See, e.g.*, *Definition*, at 14.

Professionals involved in the diagnosis and treatment of mental retardation agree that adaptive functioning is composed of a wide array of discrete skills that can be placed into categories or "domains," each of which is amenable to evaluation and testing. These skills determine whether and how effectively an individual can do everything from meeting new people, to dressing, to managing a personal banking account. Professionals have identified ten domains of adaptive skills that are assessed for the purposes of diagnosis. They are communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. *See DSM-IV-TR*, at 41; *AAMR Manual*, at 39-41; *Definition*, at 30-31. The adaptive

functioning criterion for identifying mental retardation is satisfied when the individual has substantial limitations in at least two of these domains. *See DSM-IV-TR*, at 41; *AAMR Manual*, at 39-41; *Definition*, at 30.

Clinicians have at their disposal objective rating scales and assessment methods for the comprehensive evaluation of adaptive functioning skills. Such instruments were largely developed for the express purpose of testing adaptive functioning as it relates to mental retardation, and the tests accordingly have a high degree of validity in connection with this use. *See AAMR Manual*, at 41 ("there is a relatively close correspondence between the structure of many of the [testing] scales and the implicit meanings within those definitions [of mental retardation]"). In addition to validity, the reliability of particular adaptive functioning tests has been determined through extensive and intensive analyses. *See* John W. Jacobson & James A. Mulick, *Psychometrics, in APA Manual*, at 75, 80-82.

As with intellectual functioning, the threshold for significant limitations in adaptive functioning is a domain score that is two or more standard deviations below the mean, *see Definition*, at 13, referenced to the subject's chronological age, *see AAMR Manual*, at 6; *Definition*, at 28; *see also DSM-IV-TR*, at 42. To verify the accuracy of results obtained from these instruments, the clinician usually must also interview one or more knowledgeable persons who are well-acquainted with the subject's typical, unprompted adaptive behavior. *See Definition*, at 35; *AAMR Manual*, at 45.

3. *Onset Prior to Adulthood*. The third necessary criterion of mental retardation is onset prior to adulthood. *See*

Definition, at 13; *AAMR Manual*, at 5, 16; *DSM-IV-TR*, at 41.[16] For present purposes, this criterion is important because it provides additional certainty concerning a diagnosis of mental retardation. A complete evaluation of an individual for mental retardation requires consideration of materials such as school records and reports from persons who have long familiarity with the client in order to confirm that present limitations in intellectual and adaptive functioning became manifest before adulthood. *See* Diane Courselle et al., *Suspects, Defendants, and Offenders with Mental Retardation in Wyoming*, 1 Wyo. L. Rev. 1, 20, 27 (2001). Unlike many other disabilities or diseases, mental retardation cannot appear for the first time in adults.[17] Thus, false positive diagnoses of mental retardation

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[16] This age may range from 18 to 22. *See AAMR Manual*, at 6 (18 years); *DSM-IV-TR*, at 39 (18 years); *Definition*, at 13 (22 years). The existence of this range reflects the fact that "the cutoff age for the end of the developmental period and the beginning of adulthood may be relative to the social, cultural, and ethnic milieu. . . . The critical consideration would be whether the individual was functioning as an adult in . . . society prior to the onset" of the disability. *Definition*, at 36 (quoting *AAMR Manual*, at 17). Thus, a person who initially presents symptoms of mental retardation between the ages of 18 and 22 may receive "an appropriate alternative classification" that is distinct from mental retardation if that person previously achieved adult levels of functioning. *Definition*, at 36-37.

[17] An adult who develops intellectual and adaptive limitations similar to mental retardation (*e.g.*, due to a head injury or disease) typically suffers from some form of dementia. Dementia represents "a decline from a previously higher level of functioning," *DSM-IV-TR*, at 148, whereas mental retardation is a developmental disability that prevents the attainment of higher levels of functioning in the first place. Dementia may differ from mental retardation in significant ways, including severity of intellectual and/or adaptive impairment. Therefore, whether and under what circumstances the death penalty may be imposed on persons with dementia raises questions distinct from those at issue in this case.

due to malingering (*i.e.*, the opportunistic feigning of symptoms) are essentially unknown. *See id.* at 27.[18]

B. Diagnosis of Mental Retardation Requires a Complete Evaluation by Qualified Professionals.

[18] Indeed, to the extent feigning is an issue relating to diagnoses of mental retardation, it arises because individuals with retardation try to *cover up* their disability due to the lifelong stigma that often attaches to it. *See id.* This is one reason why it is essential for qualified mental retardation professionals to perform a comprehensive mental retardation evaluation if there is any reason to believe mental retardation is present. *See generally infra* Section II.B.

The foregoing discussion explains how diagnoses of mental retardation can be made using valid and reliable tests and protocols. The corollary of this point is that the diagnosis must be made by *qualified mental retardation professionals* who conduct a *complete mental retardation evaluation* adequately covering all three necessary criteria for diagnosis (intellectual limitations, adaptive limitations, and time of onset).

The first essential prerequisite to a reliable clinical identification of mental retardation is that the evaluation be performed by *qualified professionals*. *See, e.g.*, *Definition*, at 38; Ellis & Luckasson, *supra*, at 485-87. Not every psychologist or psychiatrist is qualified to perform a mental retardation evaluation; indeed, many such professionals focus on mental illness or other issues and have no expertise relating to retardation. *See* Ellis & Luckasson, *supra*, at 485-87. Professionals without this expertise may fail to recognize mental retardation, especially "mild" retardation where an individual's IQ is around 70 and he or she has comparatively high adaptive functioning in some but not all domains.

Qualified professionals must also administer the specific IQ and adaptive functioning tests used in the mental retardation evaluation. *See, e.g.*, *AAMR Manual*, at 44. The American Psychological Association and other major professional organizations interested in the integrity of measurement methodologies have published standards that require test publishers to specify the qualifications a person must have in order to administer any given test of intelligence. *See* American Educational Research Association, American Psychological Association & National Council on Measurement

in Education, *Standards for Educational and Psychological Testing* 69, 114 (1999); *see also AAMR Manual*, at 36.[19]

The second essential prerequisite to a reliable clinical identification of mental retardation is that the evaluation be *complete*, *i.e.*, that it *adequately* cover *all three* necessary criteria for mental retardation. As explained above, mental

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[19] Experience in the identification of mental retardation and administration of IQ and adaptive functioning measurement devices is also necessary to deal with many other issues, such as evaluation of individuals from linguistic or cultural backgrounds requiring special tests or other devices, *see AAMR Manual*, at 44; *DSM-IV-TR*, at 42, 46, or individuals with sensory or physical limitations that interfere with performance on standard tests, *see AAMR Manual*, at 47. An inexperienced evaluator could incorrectly conclude that persons with these special needs have mental retardation when in fact they do not.

retardation exists only when all three criteria are met: significant limitations in intellectual functioning, *and* significant limitations in adaptive functioning, *and* onset before adulthood. Perhaps the most common shortcoming in purported evaluations for mental retardation is exclusive reliance on IQ tests (or, in some cases, IQ tests combined with some consideration of the individual's case history). Without assessment of *adaptive functioning*, however, such an "evaluation" is inherently unreliable. *See Definition*, at 14 ("Classification requires that all three criteria must be met. Psychological diagnosis based exclusively on intellectual functioning and age of onset criteria is clinically inappropriate"). This is true in all cases, but especially when an individual scores between 70 and 75 on IQ tests. Because of the standard error in those tests, such scores are ambiguous with respect to mental retardation in the absence of adaptive functioning assessments. *See supra* at 14-15.

Finally, minimal assessment of each of the three criteria is not sufficient; the assessment of each criterion must also be *adequate*. Assessment of intellectual functioning, for example, must be performed on an *individual* rather than a group basis to obtain accurate results. *See AAMR Manual*, at 25. With respect to adaptive functioning, mental retardation may exist when an individual has significant limitations in at least two of ten enumerated skill areas or "domains." *See, e.g.*, *id.* at 5; *DSM-IV-TR*, at 41. Accordingly, testing or evaluation of only some but not all domains is an insufficient basis on which to base a conclusion that an individual does *not* have mental retardation.

The importance of a complete mental retardation evaluation is illustrated by the present case. Mr. McCarver has been examined by a number of mental health professionals, but prior to Dr. Baroff, none of these clinicians appears to have evaluated Mr. McCarver for the purpose of determining

whether he has mental retardation, as opposed to mental illness. More specifically, none of the earlier examiners appears to have assessed Mr. McCarver's adaptive functioning. Yet, under the universally accepted diagnostic criteria discussed above, mental retardation can neither be confirmed nor ruled out for an individual who scores between 70 and 75 on an individual IQ test, unless the individual's adaptive functioning is also assessed. Accordingly, the opinions of the various clinicians in this case appear to reflect the different purposes and scopes of their respective examinations of Mr. McCarver, rather than conflicting diagnoses reached after complete *mental retardation* assessments.

Qualified mental retardation professionals who independently carry out complete mental retardation evaluations of an individual should reach the same conclusion about whether that individual has mental retardation. Reaching the correct result is critical where an improperly administered evaluation can literally mean the difference between life and death.

CONCLUSION

For the foregoing reasons, the death penalty should not be imposed on individuals with mental retardation.

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