

IN THE SUPREME COURT FOR THE STATE OF FLORIDA

CASE NO. SC09-262

DONALD DUFOUR,

Petitioner-Appellant,

v.

STATE OF FLORIDA,

Respondent-Appellee.

ON APPEAL FROM THE CIRCUIT COURT OF THE NINTH JUDICIAL
CIRCUIT, IN AND FOR ORANGE COUNTY, FLORIDA

**BRIEF OF AMICUS CURIAE THE AMERICAN ASSOCIATION ON
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (“AAIDD”)**

IN SUPPORT OF PETITIONER

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IDENTITY AND INTEREST OF AMICUS CURIAE

The American Association on Intellectual and Developmental Disabilities

(“AAIDD”), formerly the American Association on Mental Retardation (“AAMR”),¹ has appeared as *amicus curiae* in numerous cases involving the meaning of mental retardation, mental retardation diagnoses in the criminal justice system, and the rights of those with intellectual disabilities under federal and state law. The AAIDD/AAMR appeared as *amicus curiae* in the seminal case *Atkins v. Virginia*, 536 U.S. 304 (2002). Founded in 1876, the AAIDD is the nation’s oldest and largest interdisciplinary organization in the field of intellectual and developmental disabilities. For over 80 years, the AAIDD has educated the public about the scientific consensus regarding mental retardation.² Governmental agencies and courts use the AAIDD definitions to determine whether individuals

¹ See Robert L. Schalock, *et al.*, *The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability*, 45 *Intellectual & Developmental Disabilities* 116 (2007) (explaining why AAIDD changed its name along with shifting from “mental retardation” to “intellectual disability” without changing the clinical definition). While clinicians are generally following the AAIDD’s lead in embracing the term “intellectual disability,” this brief will refer to “mental retardation,” the term used in *Atkins* and by the Florida legislature.

² Since 1910, the AAIDD has published a consensus definition of mental retardation and information regarding the means by which it is measured. Stephen Greenspan & Harvey Switzky, *Forty-Four Years of AAMR Manuals*, in What is Mental Retardation? at 3-28. In its Diagnostic and Statistical Manuals on Mental Disorders, the American Psychiatric Association (“APA”) has adopted the AAIDD’s successive definitions of mental retardation. American Psychiatric Association, *Diagnostic and Statistical Manual of Psychiatric Disorders, Fourth Edition, Text Revision* 48 (2000) (hereafter “*DSM-IV-TR*”).

have mental retardation. *See, e.g., Atkins*, 536 U.S. at 308 n.3. The AAIDD has a vital interest in ensuring that (1) all individuals with mental retardation receive the rights and protections required by law; and (2) courts and administrative agencies employ accepted scientific principles in assessing mental retardation.

SUMMARY OF ARGUMENT

Atkins v. Virginia, 536 U.S. 304 (2002), prohibits executing capital offenders who have mental retardation. Moreover, in determining who has mental retardation and thus who is categorically exempt from the death penalty, *Atkins* requires that states apply standards that generally conform to the accepted scientific definition of mental retardation. That is, *Atkins* did not leave states free to define mental retardation; they are instead directed to craft statutes that, at a minimum, exempt those individuals fairly characterized as having mental retardation under the AAIDD/AAMR's and the American Psychiatric Association's ("APA") definitions. 536 U.S. at 317 n.22.

Measuring "intellectual functioning" is just one step in making a diagnosis of mental retardation. But the mental health profession uniformly accepts that, when using IQ tests and their resulting scores to measure intellectual functioning, the standard error of measurement or "SEm" must be applied. In light of the SEm, for diagnostic purposes, the upper IQ range for mental retardation is 70-75. *Id.* at

309 n.5. Any legal test that applies a rigid IQ cutoff below 75 is inconsistent with the scientific consensus and, thus, contrary to *Atkins*' mandate.

Undoubtedly, there is clinical consensus and *Atkins* directs the states to rely on that consensus. Yet some states, like Florida, have strayed from accepted clinical definitions of mental retardation by, *inter alia*, imposing an arbitrary IQ cutoff of 70 for purposes of measuring "significantly subaverage intellectual functioning," a required element in the definition of mental retardation. Using an arbitrary IQ cutoff is inconsistent with *Atkins*' mandate and the accepted clinical consensus.

Further, Florida law reflects a misapprehension of the appropriate way to assess adaptive behavior deficits. Objective measurements, in conjunction with social histories, should govern the process of assessing deficits, which should not be weighed against unrelated strengths.

Therefore, the AAIDD urges this Court to revisit its pronouncements regarding the assessment of mental retardation under Florida law and to reverse the Circuit Court's rulings that erroneously interpreted the relevant evidence here.

ARGUMENT

I. ASSESSING MENTAL RETARDATION CLAIMS UNDER ATKINS REQUIRES USE OF GENERALLY ACCEPTED CLINICAL DEFINITIONS SET FORTH BY THE AAIDD AND THE APA

In *Atkins v. Virginia*, the Supreme Court held that executing individuals with mental retardation violates the Eighth Amendment of the U.S. Constitution. 536 U.S. 304, 321 (2002). *Atkins* further directed the states to adopt measures for ascertaining mental retardation that “generally conform[] to the clinical definitions set forth” in *Atkins* itself. *Id.* at 317 n.22. The Court embraced two clinical definitions, each of which defines mental retardation as a disability characterized by (1) significant limitations in intellectual functioning, (2) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills, and (3) onset before the age of eighteen. *See* AAMR, *Mental Retardation: Definition, Classification and Systems Supports* 1 (10th ed. 2002) [hereafter AAMR 2002]; *DSM-IV-TR* at 41; *see also Atkins*, 536 U.S. at 318.³

A. Significant Limitations in Intellectual Functioning Is Measured by IQ Taking into Consideration the Test’s SEM

A clinical determination of “signification limitations in intellectual functioning”—or what Florida statutes refer to as “significant sub-average intellectual functioning”—involves (1) intellectual “[p]erformance that is at least

³ The AAIDD/AAMR is “the principal professional organization in the field of mental retardation” and thus “[i]ts definition is highly respected and also reflects the most current research in the field.” Richard J. Bonnie and Katherine Gustafson, *The Challenge of Implementing Atkins v. Virginia: How Legislatures and Courts Can Promote Accurate Assessments and Adjudications of Mental Retardation in Death Penalty Cases*, 41 U. Rich. L. Rev. 811, 821 (2007) (urging states to adopt the AAIDD/AAMR definition). *See also* James W. Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues*, 27 Mental & Physical Disability L. Rep. 11, 13 (2003).

two standard deviations below the mean of an appropriate assessment instrument,” *i.e.*, a standardized IQ test, (2) “considering the standard error of measurement for the specific assessment instruments used and the instruments’ strengths and limitations.” AAIDD, *User’s Guide: Mental Retardation Definition, Classification and Systems of Supports* 12 (10th ed. 2007) [hereafter AAIDD, *User’s Guide*]; AAMR 2002 at 13, 14, 15, 17, 58. Thus, there is a broad consensus in the field that analyzing IQ scores to determine intellectual performance *requires* considering the standard error of measurement.

In diagnosing mental retardation, a clinician first selects from among various options the standardized intelligence test best suited to the particular circumstances of the test-taker. If a properly administered test produces a score of approximately 70 or below, the person may be diagnosed with mental retardation, although evidence of adaptive deficits and age of onset must also be present. Because individuals in the 65-75 IQ range have similar intellectual functioning to each other, mental health professionals do not fixate on an exact cutoff when making diagnoses. Instead, mental health professionals emphasize that individualized consideration and clinical judgment is critical to assessing intellectual functioning accurately. *See, e.g.*, AAMR 2002 at 57-59 n.21. And, as reflected in the AAIDD *User’s Guide*, when analyzing an IQ score, accepted clinical practice requires considering the test’s SEM to adjust for inevitable testing errors.

1. SEM is inherent to the IQ measurement process

All measurement has some potential for error. For instance, when measuring vision, the result will be influenced by many factors—including the tools used to measure the various components of vision, the skill and care of the measurer, and whether the subject of the measurement is experiencing fatigue, headache, anxiety, or other distractions. Psychological testing has even greater potential for error because of the complexity of the phenomenon being measured. For example, error may be introduced by the examiner making a timing mistake, failing to record responses accurately, over-prompting, mishandling stimuli objects, or neglecting to repeat parts of the instructions. *See generally* Alan S. Kaufman & Elizabeth O. Lichtenberger, *Assessing Adolescent and Adult Intelligence* 197 (3d ed. 2006). Error may also be introduced by the subject's mood, general health, or other intangible factors. *See, e.g.,* James R. Flynn, *Tethering the Elephant: Capital Cases, IQ, and the Flynn Effect*, 12 *Psychol. Pub. Pol'y & L.* 170, 171 (2006) (hereafter “Flynn 2006”); AAMR 2002 at 57.

The SEM is a statistical concept that adjusts for the fact that a precise IQ score is always an unknown because no measuring tool is devoid of error. The SEM helps to address the inevitable errors in intelligence testing, thereby facilitating a more accurate understanding of obtained scores. AAMR 2002 at 58. Both the AAIDD/AAMR's and the APA's definitions of mental retardation stress

the necessity and importance of the SEM when considering IQ scores. *Id.* at 57-58; *DSM-IV-TR* at 41-42. The AAIDD summarizes the scientific consensus regarding the importance of the SEM in assessing IQ scores as follows:

. . . limitations in intellectual functioning are generally thought to be present if an individual has an IQ test score of *approximately 70* or below. IQ scores must *always* be considered in light of the standard error of measurement, appropriateness, and consistency with administration guidelines. ***Since the standard error of measurement for most IQ tests is approximately 5, the ceiling may go up to 75. This represents a score approximately 2 standard deviations below the mean, considering the standard error of measurement.***

The American Association on Intellectual and Developmental Disabilities, Frequently Asked Questions on Intellectual Disability and the AAIDD Definition, http://www.aaidd.org/Policies/faq_mental_retardation.shtml (last visited July 21, 2009) (emphasis added). That is, because of the SEM, “two standard deviations below the mean” can be as high as 75. AAIDD, *User’s Guide* at 12; *see also* § 921.137, Fla. Stat. (2009). Put another way, scores between 65-75 or lower are consistent with a mental retardation diagnosis. Flynn 2006 at 186.

Taking the SEM into account when interpreting an IQ score is neither new nor speculative. It constitutes long-standing clinical practice. *See, e.g.,* AAMD, *Mental Retardation Definition, Classification, and Systems of Supports* 11 (8th ed. 1983) (explaining that IQ testing is merely “a guideline [that] could be extended upward through IQ 75 or more, depending on the reliability of the intelligence test used”); Robert G. Knight, *On Interpreting the Several Standard Errors of the*

WAIS-R: Some Further Tables, 51(5) *J. Consulting and Clinical Psychol.* 671 (1983) (describing three methods of SEM for WAIS); Alfred L. Brophy, *Confidence Intervals for True Scores and Retest Scores on Clinical Tests*, 42(6) *J. Clinical Psychol.* 989 (1986). Failing to take the SEM into account constitutes a clear departure from accepted professional practice in scoring and interpreting any kind of psychological test, including IQ tests. The importance of the SEM is so well-established that it would be superfluous to direct experts to take it into account in a statute governing *Atkins* evaluations and adjudications. Thus, no state's statutory definition expressly refers to the SEM.⁴

2. The upper boundary of IQs indicating mental retardation is defined by a range, not a hard number

The AAIDD/AAMR has long emphasized that the upper boundary of mental retardation is best described as a *range*, not as a numerical cutoff: “If the IQ score is valid, this will generally result in a score of approximately 70 to 75 or below.” AAMR, *Mental Retardation* (1992) at 14 n.20. Moreover, the AAIDD/AAMR has long cautioned that the upper boundary is “flexible” to ensure *greater precision* because a range, rather than a hard cutoff, better “reflect[s] the statistical variance inherent in all intelligence tests and the need for clinical judgment by a qualified

⁴ See Death Penalty Information Center, *State Statutes Prohibiting the Death Penalty for People with Mental Retardation*, <http://www.deathpenaltyinfo.org/state-statutes-prohibiting-death-penalty-people-mental-retardation> (last visited July 21, 2009) (listing state death penalty statutes related to mental retardation).

psychological examiner.” *Id.* Further, clinicians have long recognized that the outer boundary of mental retardation “could be extended upward through IQ 75 or more, depending on the reliability of the intelligence test used.” AAMD, *Classification in Mental Retardation* 11 (Herbert J. Grossman ed., 8th ed. 1983); *DSM-IV-TR* at 41-42 (“it is possible to diagnose mental retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior.”). *Atkins* itself notes that “an IQ between 70 and 75” is considered to reflect the upper range of intellectual functioning in the most widely accepted clinical definitions of mental retardation. 536 U.S. at 309 n.5 (citing 2 *Kaplan & Sadock’s Comprehensive Textbook of Psychiatry* 2952 (B. Sadock & V. Sadock eds., 7th ed. 2000)).

In short, while mental health experts employ only individualized tests of intelligence to diagnose the presence of “significantly subaverage general intellectual functioning,” the experts also accept that there is no “fixed cutoff point for making the diagnosis of mental retardation,” and no score can be properly assessed in a vacuum.⁵ AAMR 2002 at 58. If, after taking the SEM into account,

⁵ Aside from the SEM, other widely recognized phenomena that affect IQ scores are the Flynn effect, the practice effect, and mental illness. See AAIDD, *User’s Guide* at 21. The AAIDD also emphasizes the importance of each of these effects in assessing the first criterion for mental retardation. Broadly speaking, the Flynn effect reflects that IQ scores tend to increase in the general population over time and thus IQ tests will yield different scores based on when they were normed. Flynn 2006 at 170. See also *Walker v. True*, 399 F.3d 315, 322-23 (4th Cir. 2005)

an IQ score is in the 70-75 range, and if there is evidence of adaptive deficits and onset before age 18, then an assessment of mental retardation is warranted.

B. Significant Limitations in Adaptive Behavior Are Based on Objective Measurements, Not Weighed Against Adaptive Strengths

The second prong of the clinical definition requires that an individual have significant limitations in adaptive behavior. This requirement is designed to ensure that an IQ score reflects a real-world disability, not merely a testing anomaly.⁶

This aspect of the clinical inquiry focuses on whether there are skills that the individual *cannot* do that someone without the disability can do.⁷ Like everyone else, individuals who have mental retardation differ substantially from one another

(remanding because district court failed to consider either the Flynn effect or the SEM); *In re Hicks*, 375 F.3d 1237, 1242-43 (11th Cir. 2004) (Birch, J., dissenting) (identifying the Flynn effect as one reason why stay of execution should have been granted and the case remanded for further findings). Practice effects refer to the impact on later test scores of previously administered IQ tests. See Alan S. Kaufman & Elizabeth O. Lichtenberger, *Assessing Adolescent and Adult Intelligence* 202 (3d ed. 2006).

⁶ The adaptive behavior prong was added to the AAMR definition in 1959 to reflect the social characteristics of mental retardation and to reduce undue reliance on IQ scores. AAMR 2002 at 24; Stephen Greenspan, *A Contextualist Perspective on Adaptive Behavior*, in *Adaptive Behavior and Its Measurements* 61, 61 (Robert L. Schalock ed., 1999).

⁷ Assessment involves standardized instruments for measuring adaptive behavior, normed on the general population, along with “a thorough social history,” which includes “a longitudinal evaluation of adaptive behavior that involves multiple raters, very specific observations across community environments (especially in regard to social competence), school records, and ratings by peers during the developmental process.” AAIDD, *User’s Guide* at 13, 18, 22.

in terms of strengths and weaknesses. Indeed, a fundamental precept in the field of mental retardation is that “[w]ithin an individual, limitations often coexist with strengths.” AAMR 2002 at 1. From a definitional perspective, an individual’s particular strengths are *only* relevant to assess corresponding weaknesses. *DSM-IV-TR* at 47; *see also Lambert v. State*, 126 P.3d 646 (Okla. Crim. App. 2005) (recognizing that unless evidence of an adaptive strength corresponds to an alleged adaptive deficit, evidence of the strength is irrelevant and should not be admitted). That is, weighing strengths against weaknesses is an improper approach to diagnosing mental retardation.

There is no clinically accepted list of strengths or abilities that preclude a diagnosis of mental retardation. *See DSM-IV-TR* (“The diagnostic criteria for Mental Retardation do not include an exclusion criterion”). Instead, clinicians consider evidence of deficits in three discernible skill sets: (1) conceptual skills, which include cognitive abilities, communication, academic skills, the use of money, and self-direction; (2) social skills, which include interpersonal relationships, self-esteem, lack of gullibility, and the ability to follow rules; and (3) practical skills, which are independent living skills such as personal hygiene, eating, housekeeping, transportation, and occupational skills. AAMR 2002 at 42. Limitations in adaptive behavior may result from not knowing how to perform a skill (acquisition deficit) or not knowing when to use a learned skill (performance

deficit). *Id.* at 73-74. Significant deficits in at least one of these three domains indicates mental retardation, regardless of strengths in other areas. *Id.* at 76.

The AAIDD recommends that adaptive behavior be assessed primarily through the use of standardized instruments. *See* AAMR 2002 at 76. These tests generally involve interviews with, or questionnaires completed by, third-parties, such as parents or teachers, who have significant experience interacting with the individual being evaluated. *Id.* at 88-90 (describing three common standardized tests). A qualified respondent will satisfy four criteria: (1) they have almost daily contact with the individual; (2) their contacts last for extended periods of time; (3) they have had these contacts within a few months of completing the interview; and (4) they have had opportunities to observe a variety of skills that the test seeks to measure. *Id.* The AAIDD also advises that the results of standardized tests should be considered in tandem with a social history because best scientific practice recognizes that “different sources of data” enable “more informed professional judgment by providing a context” to achieve a comprehensive evaluation of the person’s functioning. AAIDD, *User’s Guide* at 18, 22, 86.

Stereotypes and lay assumptions about people with mental retardation can cloud or distort individual assessment.⁸ Moreover, many of the skills in the

⁸ Clinicians have long recognized the insidious effect of stereotyping. *See, e.g.,* Michael S. Sorgen, *The Classification Process and its Consequences, in The Mentally Retarded Citizen and the Law* 215, 215-16 (Michael Kindred, *et al.*, eds.,

clinical definition of adaptive behavior are not relevant in prisons, such as self-direction, community resources, and leisure skills. And, notably, a person with mental retardation is likely to *appear* to have stronger adaptive behavior in the structured environment of a correctional facility than in society, thus possibly inflating scores that would have been indicative of mental retardation in the community environment.⁹ For this reason, experts conducting *Atkins* evaluations should focus on information relating to the defendant's adaptive skills *before* incarceration.

C. Manifestation Should Be Before Age Eighteen

Evidence of the onset of mental retardation is usually established through a social history investigation, which includes a thorough inventory of school records, medical records, and interviews with witnesses (most importantly teachers and

1976); *see also City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 454 (1985) (Stevens, J., concurring) (discussing the “history of unfair and often grotesque mistreatment” noted by experts in the field); James W. Trent, Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (1994) (describing the evolving definitions and stereotypes associated with developmental disability). False stereotyping prompted clinicians in another era to claim, for example, that “[t]he feeble-minded are a parasitic, predatory class, never capable of self-support or of managing their own affairs.... They cause unutterable sorrow at home and are a menace and danger to the community.” Walter Fernald, *The Burden of Feeble-mindedness*, 17 *J. Psycho-Aesthetics* 87, 90 (1912). History has discredited such views; and contemporary science rejects the assumption that every person with mental retardation possesses the same lack of skills or abilities.⁹ *See* Stanley L. Brodsky & Virginia A. Galloway, *Ethical and Professional Demands for Forensic Mental Health Professionals in the Post-Atkins Era*, 13 *J. Ethics & Behav.* 3, 7 (2003).

school peers) who knew the defendant in the community in which he or she grew up. AAIDD, *User's Guide* at 18-20.

II. FLORIDA’S STANDARD FOR ASSESSING MENTAL RETARDATION IN DEATH PENALTY CASES DOES NOT COMPORT WITH THE SUPREME COURT’S MANDATE

Florida’s three-part statutory definition of mental retardation partially tracks the definitions promulgated by the AAIDD and in the *DSM-IV-TR* and endorsed in *Atkins*.¹⁰ See Fla. R. Crim. P. 3.203; § 921.137, Fla. Stat. Florida’s statutory definition does *not*, however, explain how to measure “significantly subaverage intellectual functioning.” *Id.* Specifically, the Florida definition contains the first two elements of the standard AAIDD definition of “significantly subaverage intellectual functioning,” but does not expressly explain that, in interpreting standardized IQ tests, clinical practice *requires* “considering the standard error of measurement for the specific assessment instruments used and the instruments’ strengths and limitations.” AAIDD, *User's Guide* at 12; AAMR 2002 at 13, 14, 15, 17, 58. A visual comparison is instructive:

Fla. R. Crim. P. 3.203; § 921.137, Fla. Stat.	AAIDD, <i>User's Guide</i> at 12; AAMR 2002 at 13, 14, 15, 17, 58
<ul style="list-style-type: none"> • performance that is two or more standard deviations below the mean score • on a standardized intelligence test authorized by the Department of 	<ul style="list-style-type: none"> • performance that is at least two standard deviations below the mean • of an appropriate assessment instrument [<i>i.e.</i>, a standardized IQ

¹⁰ Florida’s statutory definition, adopted in 2001, is based on the AAIDD/AAMR’s older 1983 definition of mental retardation. See FL Staff An., S.B. 238, 2/14/2001.

Children and Family Services in Rule 65B-4.032 of the Florida Admin. Code	test] • considering the SEM for the specific assessment instruments used and the instruments’ strengths and limitations
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The fact that Florida does not include an explicit reference to the SEM should not mean that under Florida law “significantly subaverage general intellectual functioning” can be based on an arbitrary IQ cutoff or that the SEM can be ignored. To the contrary, the SEM *must* be taken into account if an assessment regarding mental retardation is to “generally conform[] to the clinical definitions” as *Atkins* requires. 536 U.S. at 317 n.22. Imposing a correlation between “significantly subaverage general intellectual functioning” and a specific IQ cutoff conflicts with accepted scientific practice. *See, e.g.,* Richard J. Bonnie, *The American Psychiatric Association’s Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. Am. Acad. Psychiatry Law 304, 305-06 (2004) (stating the APA’s position that “incorporation of a specific cutoff score is inappropriate”).

Yet that is precisely how Florida courts have interpreted the state’s statutory definition. *See Cherry v. Florida*, 959 So. 2d 702 (Fla. 2007); *Jones v. State*, 966 So. 2d 319, 329 (Fla. 2007). The approach applied in cases such as *Cherry* and *Jones*, in which the Court applied an arbitrary IQ cutoff of 70 without properly accounting for the SEM, is at odds with *Atkins* and the standard scientific

understanding of mental retardation. The use of an arbitrary cutoff is contrary to the U.S. Supreme Court’s mandate that states, while free to establish their own procedural rules, must use standards that adhere to the scientific and clinical definitions of mental retardation adopted by the AAIDD and the *DSM-IV-TR*. *Atkins*, 536 U.S. at 317 n.22; *see also Hall v. Quarterman*, 534 F.3d 365 (5th Cir. 2008) (holding district court unreasonably denied *Atkins* claim in part because decision was based on state court’s erroneous interpretation of defendant’s IQ score). Indeed, under the current construction of Florida’s statutory definition, persons who would be considered to have mental retardation under accepted scientific and clinical standards are being deemed eligible for execution.

Other states have properly rejected the notion of a rigid IQ cutoff in making mental retardation determinations, including California, Mississippi, Louisiana, Pennsylvania, and Massachusetts. *See, e.g., People v. Vidal*, 155 P.3d 259 (Cal. 2007) (rejecting bright-line IQ cutoff and interpreting the state’s statutory definition of mental retardation to require a complete factual analysis to determine whether a defendant has “subaverage general intellectual functioning”); *In re Hawthorne*, 105 P.3d 552 (Cal. 2005) (same); *Chase v. State*, 873 So. 2d 1013, 1028 (Miss. 2004) (explaining that, under prevailing definitions approved in *Atkins*, mental retardation “may, under certain conditions, be present in an individual with an IQ of up to 75” and emphasizing that IQ alone “does not determine mental

retardation”); *Louisiana v. Dunn*, 831 So. 2d 862, 884, 887 (La. 2002) (ordering hearing on mental retardation where defendant had IQ score of 71 to consider the SEM and other factors); *Commonwealth v. Miller*, 888 A.2d 624, 629-31 (Pa. 2005) (recognizing importance of the SEM in assessing IQ scores); *Melican v. Morrisey*, 2006 WL 10755465 (Mass. Super. Mar. 13, 2006) (analyzing IQ scores, quoting AAMR materials regarding the SEM, and concluding that plaintiff qualified for disability benefits with IQ score of 75). Further, courts in other jurisdictions have recognized that statutes defining mental retardation need not explicitly mention the SEM in connection with measuring “subaverage general intellectual functioning,” because the role of the SEM in interpreting IQ scores and assessing intellectual functioning is widely accepted scientific practice. *See, e.g., Vidal*, 155 P.3d at 267 (discussing statutory definition of mental retardation virtually identical to Florida’s).

The divergent constructions of *virtually identical statutory language* in different jurisdictions is profoundly troubling, especially considering the context. These differences mean that the same offender could be eligible for execution in one state but not in another. *See* Lois A. Weithorn, *Conceptual Hurdles to the Application of Atkins v. Virginia*, 59 Hastings L.J. 1203, 1231 (2008) (“[A]s the comparison between Florida’s and California’s use of standardized IQ tests suggests, there are noteworthy inconsistencies in the ways in which state courts are

using these tests. This result is disturbing in light of the dramatic consequences of the application of these tests in the Atkins context.”). This disparate application of *Atkins*, based on different constructions of the *same* statutory language reputedly based on the *same* clinical definitions, offends the Eighth Amendment, which demands consistent and non-arbitrary application of the death penalty. *See Kennedy v. Louisiana*, 128 S. Ct. 2641, 2665 (2008) (ensuring against “arbitrary and capricious application” of the death penalty requires that its use be restrained).¹¹

This Court, in suggesting that *Atkins* gave unfettered discretion to the states to define mental retardation, has promulgated an incorrect statement of law. *See Jones*, 966 So.2d at 327. Under *Atkins*, Florida is not free to define mental retardation in contravention to the clinical consensus. Instead, in the death penalty context, Florida’s definition of mental retardation *must* conform to standard clinical understanding. *Atkins*, 536 U.S. at 317 n.22. Yet with regard to both the interpretation of IQ scores and the proper assessment of adaptive deficits, Florida has gone off course. *See, e.g., Cherry*, 959 So. 2d 702 (incorrectly concluding that Florida’s statutory language that refers to “two or more standard deviations below the mean score” is synonymous with a raw IQ score of 70 or below); *Jones*, 966

¹¹ *See, e.g., Ellis, supra*, n.3; Richard J. Bonnie, *The American Psychiatric Association’s Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. Am. Acad. Psychiatry & L. 304, 305-06 (2004).

So.2d 319, 327-28 (improperly rejecting expert testimony regarding adaptive behavior before age 18 and focusing on evidence of defendant's routines in prison and adaptive strengths instead of deficits).

Ostensibly following this Court's lead, the trial court in this case has strayed even further afield from commonly accepted clinical understanding. With respect to Mr. Dufour, the trial court erred by improperly using the SEM to conclude that IQ scores *below* 70 were really above the state's arbitrary cutoff of 70. *State v. Dufour*, No. 1982-CF-5467, 9-10 (Fla. 9th Cir. Ct. Dec. 19, 2008). Properly accounting for the SEM, Mr. Dufour's scores show significantly subaverage intellectual functioning. The trial court also erred in assessing Mr. Dufour's adaptive deficits, improperly weighing Mr. Dufour's adaptive *strengths* against unrelated deficits and unsound assumptions about his alleged "street smarts." *Id.* at 10-18. Further, the court made numerous assumptions about Mr. Dufour's mental capacity that are contrary to the clinical judgments of appropriately qualified and experienced experts in mental retardation. For instance, the court gave undue weight to evidence regarding Mr. Dufour's behavior in prison, *id.* at 13-14; gave insufficient weight to credible opinions of trained clinicians in the best position to assess mental retardation and relied unduly on lay testimony, *id.* at 5-10; and made a finding about age-of-onset contrary to the great weight of the evidence, *id.* at 18-19.

CONCLUSION

The U.S. Supreme Court has correctly observed that diagnosing mental retardation is less complex than many forms of mental illness. *Heller v. Doe*, 509 U.S. 312, 321-22 (1993). In diagnosing mental retardation, there are objective measures of intellectual functioning and objective means to assess deficits in adaptive skills and vast consensus with the mental health profession as to how best to assess mental retardation. The rulings under review conflict with professionally accepted scientific standards. Specifically, the rulings do not properly consider the SEM in interpreting Mr. Dufour's IQ scores or the range of scores relevant to assessing his intellectual functioning. Nor do the rulings reflect standard scientific methodology for determining deficits in adaptive behavior. Additionally, the court's rulings do not account for the substantial evidence of onset before age 18. To the extent that these rulings correctly interpret Florida law, Florida law is at odds with both the *Atkins* decision and contemporary scientific understanding in terms of (1) the erroneous notion that "significantly subaverage intellectual functioning" correlates to an arbitrary IQ cutoff of 70 and (2) the misconceptions as to how to measure adaptive behavior deficits. Therefore, the AAIDD respectfully asks that this Court reverse the rulings below that denied Mr. Dufour's motion for determination of mental retardation as a bar to execution.

Date: _____, 2009

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH FLA. R. APP. P. 9.210

Undersigned counsel hereby certifies that this brief complies with the font requirements of Florida Rule of Appellate Procedure 9.210(a)(2) in that the printed brief is in Times New Roman, 14-point font and otherwise comports with the Rule.

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