No. 24-872

Supreme Court of the United States

JOHN Q. HAMM,
COMMISSIONER OF THE ALABAMA
DEPARTMENT OF CORRECTIONS,
Petitioner,

v.

JOSEPH CLIFTON SMITH,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

JOINT APPENDIX
VOLUME III OF III

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FORENSIC PSYCHOLOGICAL EVALUATION
FORENSIC NEUROPSYCHOLOGICAL EVALUATION

INTELLECTUAL DISABILITY EVALUATION

State of Alabama vs. Joseph Smith

2/24/17

DEFENDANT: Joseph Smith
DATE OF BIRTH: [redacted]
AGE: 45 Years
CHARGES: Capital Murder
DATES OF EVALUATION: 10/20/2014, 10/21/2014, 10/23/2014, 12/03/2015

LEGAL REFERRAL:

Kacey Keeton, attorney, referred me to examine her client, Mr. Joseph Smith, for a forensic psychological and neuropsychological evaluation. She had concerns about Mr. Smith's neuropsychological and cognitive functioning and whether he is intellectually disabled.

This examination will address whether Mr. Smith is intellectually disabled.

STATEMENT OF NON-CONFIDENTIALITY/ INFORMED CONSENT:

Prior to my examinations with Mr. Smith at Holman Correctional Institution in Holman, Alabama (Alabama's death row prison), I informed him of the nature and purpose of the evaluation. I informed him that I was evaluating his psychological and neuropsychological functioning and wanted to examine different areas of

neurocognitive functioning. I did not formally express to him that I was examining whether he had an intellectual disability or not. I informed him that his attorney and legal team would decide whether they wanted to utilize this evaluation in court. He understood the nature and purpose of the evaluation as to the extent I expressed it to him. He understood that I could testify to this information in a court of law. Mr. Smith had also spoken with his attorney, Ms. Keeton, who had explained to him the nature and purpose of the evaluation. He understood these issues and agreed to proceed.

SOURCES OF INFORMATION:

1. Forensic and clinical interviews with Mr. Smith.
2. Neuropsychological Assessment Battery.
3. Green's Emotional Perception Test.
4. Category Test.
5. Independent Living Scales.
6. Expressive One-Word Picture Vocabulary Test.
7. Receptive One-Word Picture Vocabulary Test.
8. Stanford-Binet Intelligence Scale, Fifth Edition.
9. Behavior Rating Inventory of Executive Functioning-Adult Version.
10. Social Cognition Test.
11. Delis-Kaplan Executive Function System.
12. Repeatable Battery for the Assessment of Neuropsychological Status.
13. Test of Premorbid Functioning.
14. Woodcock-Johnson Test of Academic Achievement, Third Edition.
15. Test of Memory Malingering.
15. Baldwin County School records.
17. Review of Dr. Chudy report.
18. Baldwin County School records.

19. Records provided by Middle District of Alabama Federal Defender's Program, Capital Unit.

20. Discussion with Mr. Smith's mother, Glenda Smith.

21. Interview with Melissa Espinal, collateral informant

22. Interview with Melanie Logan, collateral informant.

23. Interview with Lynne Smith, sister of Mr. Smith.

24. Phone call to Judy Smith.

It should be noted that the following sections are summaries from Mr. Smith's self-report. Along these lines, Mr. Smith is low functioning and has not always been consistent with his self-report. His recall is also deficient due to cognitive limitations and is sometimes contradicted by record reviews and interviews with others. Further, forensic psychologists should not rely solely on defendant self-report, but consider collateral sources of information.

BACKGROUND FAMILY HISTORY:

Mr. Smith was born in Baldwin County, Alabama. His parents are Leo and Glenda. His parents were married. He reported they divorced when he was 9 years of age. He said his mother reported his father was abusing alcohol. He did recall his father was mean and abusive and he would beat Mr. Smith's mother. He reported having siblings including Becky, Jason, Chris, and Lynne. They are full-blooded siblings. When asked about his parents' level of education, he stated that his mother did not finish school but she obtained her GED. He also reported that his mother was regularly employed in home healthcare.

I asked Mr. Smith about any abuse by his father, and he did state his father was physically abusive to him and would beat him with belts. He said his father

would hit him with a fan belt or water hose. This would occur about once or twice per week. The father also beat the other brothers two to three times per week; therefore, there was regular physical abuse by the father to the children, as well as to the mother. He added that he witnessed domestic violence all the time.

His parents divorced and his mother then married a man named Hollis when Mr. Smith was about 9 or 10 years of age. He said both his parents remarried, and his father married a woman named Connie. After his parents divorced, he lived with his mother and then his father. He shuffled back and forth. He described his step-father as being worse than his father and there was a lot of abuse to the children and to the mother. He reported the beatings were frequent. He would be hit by a 2x4. He said there was emotional and verbal abuse by both his father and step-father. He reported his mother and step-father divorced.

Mr. Smith reported that he was unaware of any social services investigations for abuse or neglect. He denied a history of sexual abuse by anyone.

Developmentally, Mr. Smith did not know about his mother's prenatal care for him. He said that he was unaware of any birth complications. He did not believe she used alcohol or drugs during her pregnancy with him. He denied knowledge of any type of speech, hearing, vision, or language problems. He said that he did not recall being diagnosed with ADHD, but he said, "I may have had the disorder." He believed he was in special education classes and had difficulties with comprehension.

ACADEMIC HISTORY:

Mr. Smith reported completing the 7th grade and then dropped out, "I don't really know why." He

attended Alabama Public Schools. He stated he was not interested in school. He attended a number of schools, "I would really switch back and forth with my mom and dad, living with them, and I would then go to different schools." Mr. Smith noted he had a difficult time learning how to read. When I asked about learning disability classes, he said he believed he was in them and he reported being in smaller classes. He said he recalled at certain times and ages he would go to school and he would show up and then "leave" and be gone. He said he had difficulty staying on task and staying still. He occasionally acted out. He described some emotional problems. He described problems with restlessness, inability to appreciate consequences, and problems with distractibility and poor attention. Mr. Smith said he repeated the 6th grade. He reported that he had difficulty in school and his parents were not overly committed to his education. He said that a lot of his disinterest in school had to do with his poor academic success.

EMPLOYMENT HISTORY:

Mr. Smith stated that he worked in the landscaping business. He also worked in painting and roofing. He reported also working in an offshore crew boat supply type of business. His first job was landscaping, and he was working all year around, and then worked part time. He said that he never worked for a company but did odd job landscaping and did not pay taxes. He said he never had a full-time taxed type of job. He usually worked under the table for contractors and landscape businesses. His longest job was as a landscaper for a few years. He said, "I grew up knowing how to cut grass and mow grass." He said he worked for that crew boat job after a few months they wanted him to fly in

a helicopter to other rigs, but he was afraid of flying and quit the job.

ACTIVITIES OF DAILY LIVING:

When asked about his activities of daily living, Mr. Smith stated he never had a bank account. As noted, he never paid taxes. He said, "I did not trust the bank." When I asked him about banking, he then said, "Too many banks get robbed, so I don't use them." He lacked the depth of appreciating of how he could use a bank. He then said, "I really thought they'd steal my money." He then talked about examples of the Chase Bank having to be bailed out. His thinking was very concrete as to the nature of how banking could be useful in his life. He said he never saved money, never had a checking account, savings account, credit card, and he did not know what credit was. He said that he never had to worry about the future and when I asked him about having money saved for emergency situations, he lacked any insight as to why this would be important. He never seemed to give much thought to the future and what dilemmas or situations he might encounter in life and how to problem solve and prepare for such problems.

Mr. Smith stated he lived by himself in the community. He then stated that he stayed in hotels. He also lived in his own trailer that he rented. I asked him if he had enough money to pay bills, and he said, "I did run out of money." He denied ever being evicted. He denied ever being homeless. He said he always had a place to live. He reported that he would rely on his mother for extra help and money. He never tried to obtain a driver's license. He reported that while not having a driver's license he would drive illegally. He never had any insurance. He lacked an ability to accurately describe and appreciate how auto insurance

would work or why it was important. He simply said it was a waste of money. He never appreciated how much trouble he would be in if he caused a car accident and was at fault injuring someone else. He also never tried to obtain his GED. He never liked studying. I asked if he ever had medical care, and he said he did not have any medical care before his arrest as an adult. He again lacked any understanding as to why this would be important. He stated he lost some teeth, and I did see that he lost about all of his teeth. He said he never had dental care. He did not know how to obtain dental care on the street. He did report being able to clean the house and wash his clothes by himself. He reported being able to cook food by himself. He said that he would make barbecue and make soup and fried chicken. He would fry fish and shrimp and boil potatoes.

I asked him about transportation and getting around in addition to driving. He stated that he did not use a bus. He had never been in a taxi. He believed he could utilize a map. He again talked about driving a car without a license and without insurance. He said he would occasionally drive to a store or a fast food restaurant. He believed he could order food from a fast food restaurant. He also stated he filled out job applications by himself for the offshore boating job.

I asked Mr. Smith about whether he worked on his case, and he responded, "I have difficulty reading and understanding the law. There's really no point in trying. I felt the same way in school." He again reported struggling with school and academics and had difficulties with comprehension and understanding things, which also affected his motivation and self-esteem.

I asked him again about use of money, and he stated that he could count change. I asked him what he would do for fun recreationally in the community, and he

stated he would swim and camp. He said he had camping equipment, sleeping bag, quilts, lanterns, kerosene lamp, and a tent. He also reported liking to fish and hunt hogs and deer. He reported being able to buy food and plan an outing. He would go out with his friend and brother. He said he was able to tell time but never used a watch. He said he did not watch much television.

ADAPTIVE FUNCTIONING INFORMANT:

I interviewed Melissa Espinal who is an adaptive informant for Mr. Smith. Melissa reported that Mr. Smith was dating her sister and he was a friend of her father. She recalled that she and her sister were about 14 or 15 years of age at the time and Mr. Smith was 25 years of age. She described him as acting like a kid, himself. She stated that he "carried on with my sister like he was acting younger than his age. He would laugh, joke, and play. He was very childish. There was an emotional connection of friendship. He was a lot older than me and Melanie. He had always talked to anyone who talked to him. He really tried to fit in with other people. He seemed to get picked on and was rejected. He then kept to himself. He was always trying to fit in with the group. Melissa described Mr. Smith being connected with her sister. She said he never took advantage of her, but rather he felt connected with her. Melissa again commented that she remembered him acting childish and laughing. She stated it was not normal to have someone his age who is hanging out with kids that young. She said, "My sister told me that he could not read or write." She said he was very suggestible, "If at any time someone came up to him and said let's party, he would just do it. He wanted to fit in, he was so easily led. He was really mostly a follower." She also recalled him living with

Melissa and her sister and his father at a hotel. She said, "I don't know why his father was there. I know his father would work and then sit on our stoop and drink alcohol." She reported that Jodi (nickname for Joseph Smith) was arrested and had been in jail. She said that he did not have permanent plans on where to live and where to work. She did not believe that he was working all the time. Melissa also described him as drinking alcohol and he got drunk frequently but was not mean. She again described him as being very gullible and easily led and followed others, "He'd jump into things before thinking about them." She reported never seeing him cook food or prepare meals. She said he would eat some of their own food they bought. "I never saw him buy groceries, and I don't know if he groomed regularly and don't know if he washed clothes."

Melissa reported that she believed Mr. Smith worked odd jobs with his father. She said he did side jobs. She did not think that he could be responsible enough to work an everyday full-time job. She described him as "a wanderer. Anywhere he could go and drink. I really don't know if he had any money. I never saw him drive a car. He never had a driver's license. During the day, he would hang out with different people when he was at the hotel. Many of the people he hung out with did not work and often drank alcohol. He really had no plan for the future and he was very suggestible to do whatever someone else was doing."

I also interviewed Mr. Smith's mother, Glenda. She was living in a nursing home at the time. She described her pregnancy with having prenatal care for Jodi. She had a normal delivery. She denied birth complications. She had no use of alcohol or drugs during pregnancy. She reported that her son had a learning disability and had problems with comprehension.

When asked about adaptive functioning, Glenda reported, "My son has always been a follower. He had difficulties with anger. He had difficulties controlling his behavior." She described traits of ADHD, especially after she had learned about the disorder on television. She reported a number of symptoms of ADHD for him and said he had problems following rules, paying attention, low frustration tolerance, and was involved with anger management classes. She said he always struggled in school. She believed he was in special education type of classes. She said he was never involved in any extracurricular activities and did not have significant friendships with other peers his age. She did not know about his alcohol use, especially at such a young age. When asked about his work experience, she said she knew that he had some work experience but was not always employed. She denied that he worked a regular full-time job. She said that he did not have a bank account. She acknowledged him driving illegally without insurance. He never was able to afford a car or insurance. She said that they did not have a bus nearby and he was not using public transportation. Glenda said he never took very good care of himself, he had had no medical or dental insurance and had lost teeth.

I also interviewed Melanie Espinal, who is Mr. Smith's old girlfriend. She said she was about 14 or 15 years of age when Jodi was 25 years of age. She reported her parents had separated and she lived with her sister and mother. They lived in a hotel. She described her father as being abusive and beating the mother and children. He was an alcoholic. She said, "My father had picked me and Melissa up one morning, and he had Jodi with him. Jodi started coming around more on his own, and his father stayed at the hotel." She said, "We'd hang out together."

Melanie stated she had known Mr. Smith for about a year. She said that he did not work when she knew him. She described him as "bugging my dad for money. I do not think he had a driver's license. I don't really remember him liking me. I remember us hanging out a lot overnight." I asked Melanie why he was hanging out with someone so young such as her, and she said, "I was not really mature, but I ran around at that time, and he acted very young for his age. I know he tried to impress me. He was a grown man trying to impress me as a kid."

Melanie described Jodi as having difficulty understanding things, "He always asked and said, 'What does that mean?'" She always believed he should know a lot more than he did for being so much older, but she described him as being limited. She again described him as acting much younger for his age and was immature. She said, "When I met him, we were really on the same wavelength. He was fun to be around, and he would jump fences and do risky things, and would climb around. He'd jump in the window. When he came around, I really felt like a kid, but I was older for my age due to my mom and dad's situation, and I needed to take care of my mom because of her health. I remember Jodi had such a good heart about everyone. He was easily led."

I also interviewed Mr. Smith's sister, Lynne. She reported a very dysfunctional family and described her mother and father as the center of that dysfunction. She also reported abuse by her step-father. The family moved around frequently in Alabama. She described a lot of violence between her mother and step-father. She said that both her step-father and father abused her mother. She described that her step-father was even more abusive to the mother and boys than her father

was. She stated that her brother, Jodi, had behavioral problems. She said he had burns on his legs. It is my understanding that Mr. Smith's father was grilling and coals fell on the ground, Mr. Smith threw gas on the fire, and then caught himself on fire. His mother then took him to the hospital. She reported that he did not have many friends. She said he was picked on by others, was easily led, gullible and naïve. She described him as struggling in school and had difficulty comprehending things.

It should be noted, that Lynne was very emotionally distraught during my interview with her. She had never processed these traumatic experiences and it was very difficult for her to reflect on her prior trauma as a youth. She denied any counseling history and said that she has only dealt with it during her discussions with professionals on Jodi's case. She also had not lived with Jodi in some time, and had difficulties with reflection on specifics as to his adaptive functioning.

These informants had not been involved with Mr. Smith's life for many years, and it was difficult and at times traumatic to remember facts from this long ago.

RELATIONSHIP HISTORY:

Mr. Smith reported never being married. He did state that he lived with a female in the past when he got out of jail in 1996. He said this woman's name was Vivian Whitfield. He met her at a motel lobby. They dated for a few weeks and then she moved in with him. They lived together for about four or five months. He denied ever being married and he has no children.

MENTAL HEALTH HISTORY:

Mr. Smith denied any inpatient psychiatric treatment history. He acknowledged a history of self-

mutilation and potential suicidality. He said that when he was about 15 years of age he slit his wrists and watched them bleed. When he was 17 years of age, he said on one occasion he went drinking and he was on his own. He was on a dirt road and it was raining while driving. He was driving as fast as he could and pulled the emergency brake. When asked why he did this, he stated he did not know why. He did not know if he was suicidal at the time. He said he woke up on the steering wheel and it was bent. He said he hit a dirt bank. He recalled, "It was dark when it happened. When I woke up, I walked to my friend's house." He did not know if he lost consciousness. He reported no significant evidence of mental health treatment. He stated again that he self-mutilated by cutting himself. He denied any formal suicide attempt history. [redacted]. He did not know why he was prescribed these medications. He said he was in prison and had never asked for such medications.

During the current evaluation, Mr. Smith did not endorse any significant evidence of mental illness, such as major depression, bipolar disorder, psychosis, chronic anxiety, or PTSD. He did state that his abuse and neglect experienced and witnessed caused him some emotional problems, but he did state he would stuff his feelings and not deal with them. He was not involved in individual therapy.

Mr. Smith denied ever being connected with the Mental Retardation Developmental Disability Board.

MEDICAL HISTORY:

As noted, Mr. Smith does have a history of head injury. He described a traumatic brain injury at 17 years of age due to the car wreck. He hit his head against the windshield. He also reported getting stuck with an ink pen in the right temple while in jail. He also reported hitting his head on a steel horse trailer. He did not believe he lost consciousness. He said he was stunned a few times with blows to the head. He also reported that his step-father beat him on the left side of his head with an axe handle. He stated that he was hit a number of times to the head due to fights and accidents. He denied significant evidence of loss of consciousness, but he did report feeling dazed on a number of occasions. He also has not received treatment for these blows to the head. Ms. Smith also reported losing the top portion of his left ear after his step-father hit him in the head with a baseball bat.

[redacted]

SUBSTANCE USE HISTORY:

Mr. Smith reported using alcohol daily in the past. He was drinking beer. He said his daily use was accelerating by 12 years of age, which is when he first started experimenting. He said that he would drink beer and eventually was drinking more frequently. He was even using with his step-father. After 12 years of age, he continued drinking beer even more frequently. He eventually developed a tolerance to alcohol and needed more to get the same effect. He said that by the time he was 15 years of age he would go to buy beer at the store. He was drinking every day of the week. He reported usually drinking to intoxication. He said at some point his parents knew that he was drinking. He

often would drink beer and liquor. He did not want to cut back and believed he could control his use of alcohol. He said he did not drink at work. He did experience some blackouts. He commented, "I have heard that I've had blackouts." His alcohol use history is positive for an alcohol use disorder and alcohol dependence.

Mr. Smith reported never using illegal drugs. He said he did participate in alcohol and drug classes while in prison.

LEGAL HISTORY:

Mr. Smith reported no juvenile criminal record. As an adult, he was sent to prison at 19 years of age. He was released out on parole at 26 years of age. He was out for one year and had a parole violation for drinking and fighting. He went back to prison for about a year. He left there and went on work release. He did not receive any significant training while in prison and no certifications. He did recall being stabbed in jail during his pretrial incarceration for the instant capital offense.

CURRENT NEUROPSYCHOLOGICAL & PSYCHOLOGICAL TESTING RESULTS:

Premorbid Functioning

Mr. Smith was administered the Test of Premorbid Functioning, which is a word reading list that gives an estimation of premorbid functioning. His premorbid functioning score was a standard score of 83, 13th percentile.

Intellectual Functioning

Mr. Smith was administered the Stanford-Binet Intelligence Scale, Fifth Edition, to assess for current IQ. He had a full scale IQ of 78, 7th percentile. His

nonverbal IQ was a standard score of 75, 5th percentile, while verbal IQ was a standard score of 83, 13th percentile.

Fluid reasoning skills assessing early reasoning and verbal analogies included a standard score of 76, 5th percentile. Knowledge domain assessing skills and knowledge acquired by formal and informal education, yielded results that included a standard score of 86, 18th percentile. On the quantitative reasoning domain assessing knowledge of mathematical thinking, such as number concepts, estimation of problem solving and measurement skills, the results included a standard score of 78, 7th percentile. On the visual/spatial processing domain assessing one's ability to see patterns of relationships and spatial orientation, the results were a standard score of 79, 8th percentile. On the working memory domain assessing cognitive processes of temporarily storing and then transforming or sorting information and memory, the results included a standard score of 89, 23rd percentile.

Academic Achievement

Mr. Smith was administered the Woodcock-Johnson Test of Academic Achievement, Third Edition, to assess for academic achievement skills. His overall achievement was below average (SS=87, 7.1 grade equivalent and 12 years 5 months age equivalent).

His skills in reading single words were below average (SS=89, 7.5 grade equivalent). Math calculation skills were below average (SS=84, 5.9 grade equivalent and 11 years 3 months age equivalent). His spelling skills were below average (SS=86, 6.3 grade equivalent and 11 years 9 months age equivalent). Reading passage comprehension skills were average (SS=96, 11.4 grade equivalent and 16 years 11 months age equivalent).

Mathematical applied problems skills were below average (SS=86, 7.2 grade equivalent and 12 years 7 months grade equivalent).

Neuropsychological Functioning

Mr. Smith was administered the Repeatable Battery for the Assessment of Neuropsychological Status. He had a total scale standard score of 83, 13th percentile and below average range. Immediate memory domain standard score was 65, 1st percentile, moderately to severely impaired range. Visuospatial/constructional domain was a standard score of 92, 30th percentile, average range. Language domain was standard score of 97, 42nd percentile, average range; attention domain was standard score of 100, 50th percentile, average range; and delayed memory domain was standard score of 84, 14th percentile, low average range.

Attention Functioning

On a Neuropsychological Assessment Battery, Mr. Smith was correctly oriented in all spheres to self, time, place, and situation. Simple attention with digits forward was above average (T=67, 96th percentile) with longest span of digits 9 in sequence, which was above average to superior (90th percentile). Digits backward assessing working memory was above average (T=60, 84th percentile) with longest span of digits 5 in sequence, which was average (50th percentile).

On the Repeatable Battery for the Assessment of Neuropsychological Status, attention domain was average (50th percentile). Simple attention on a digit span task was superior (ss=14, 91st percentile). Psychomotor processing speed on a coding task was mildly impaired (ss=6, 9th percentile).

Memory Functioning

Immediate memory on the Repeatable Battery for the Assessment of Neuropsychological Status was moderately to severely impaired (1st percentile). His skills in recalling a list of words across several trials was severely impaired (ss=3, 1st percentile), while his immediate recall of short story information was mildly to moderate impaired (ss=5, 5th percentile). Delayed memory of the initial word list was low average to average range (17th to 25th percentile). His list recognition skills were mildly to moderately impaired (39th percentile). His story recall was average (ss=8, 25th percentile). Visual delayed recall skills were average (ss=9, 37th percentile).

Language Functioning

On the Neuropsychological Assessment Battery, auditory comprehension and skills in following auditory commands were below average (T=41, 18th percentile).

Mr. Smith was administered the Expressive One-Word Picture Vocabulary Test assessing expressive language. He was given individual pictures and had to provide a one-word description and word for the picture such as microscope. He scored a standard score of 67, 13 years 5 months age equivalent and 1st percentile and moderately to severely impaired range.

He was also administered the Receptive One-Word Picture Vocabulary Test in which I provided to him four pictures and then gave him a verbal word, and he had to receive the information and point to the correct picture. He had a standard score of 71, 15 years 10 months age equivalent and 3rd percentile and mildly to moderately impaired in range.

On the Repeatable Battery for the Assessment of Neuropsychological Status, language domain was average (42nd percentile). Verbal expressive language skills were average (51st to 75th percentile), while verbal fluency skills were average (ss=9, 37th percentile).

Visuospatial / Perceptual Reasoning Functioning

Visuospatial/constructional domain on the Repeatable Battery for the Assessment of Neuropsychological Status was average (30th percentile). His skills in copying a complex figure were above average (ss=13, 84th percentile), while visuospatial skills on the line orientation task were mildly to moderately impaired to mildly impaired (3-9th percentile).

Executive Functioning

On Neuropsychological Assessment Battery, cognitive flexibility and planning on a Mazes task (T=40, 16th percentile) was below average. Social comprehension and judgment skills were average (T=53, 62nd percentile). Verbal abstract reasoning skills on a Categories task in which I gave him photos and information about six different people and he had to differentiate the people based on this information yielded results that were mildly to moderately impaired (T=33, 4th percentile).

Mr. Smith was administered the Category test. This is a test of nonverbal abstraction reasoning skills that is sensitive to frontal executive brain dysfunction. He had to understand the concepts and respond to limited feedback while displaying abstract and perceptual reasoning skills. His overall performance was mildly to moderately impaired (T=33, 4^{th} percentile), suggesting some executive and frontal lobe dysfunction.

Mr. Smith was administered the Tower Test, which assesses one's spatial planning, rule learning, inhibition, impulsive and preservative responding, and ability to establish and maintain instructional set. He scored in the average range (ss=10, 50 percentile). However, there was evidence of impulsivity with rule violations, and he had difficulties recalling the specific rules of the test (ss=4, 14th percentile).

Mr. Smith was also administered the Color-Word Interference Stroop Test measuring his ability to process information, as well as inhibit dominant and automatic response. His processing of colors was average (ss=9, 37th percentile), as was processing words (ss=10, 50th percentile). However, when he had to inhibit an automatic response assessing impulsivity, his performance was severely impaired (ss=1, 0.2 percentile), while inhibition/switching skills were also severely impaired (ss=2, 0.1 percentile).

Mr. Smith was administered the Behavior Rating Inventory of Executive Functioning-Adult Version, which is a self-report of everyday executive functioning skills. There was significant evidence of executive functioning deficits. His Global Executive Composite Score was elevated (T=69 96th percentile). His Behavioral Regulation Index and the Metacognitive Index both were also elevated (T=69, 98th percentile and T=66, 95th percentile). He reported difficulties with his ability to adjust to changes in task demands, monitor social behavior, sustained working memory, plan or organize problem solving approaches, and attend to task-oriented output. He denied problems with inhibiting impulsive responses, modulating emotions, initiating problem solving activity, and organizing environment and materials.

When looking at the individual clinical scales, he reported a significant problem on the shift scale (T=69 98th percentile). He has difficulties making transitions and tolerating change and showing evidence of problem solving flexibility or switching and alternating attention. On a self-monitor scale, there was significant elevation (T=73, 99th percentile), and he perceived himself as having difficulties monitoring his own social behavior, saying things without thinking, and not thinking about consequences before he does something, for example.

On the working memory scale, there was a clinically significant elevation (T=72, 99th percentile). He reported having problems concentrating on tasks, difficulties with jobs or tests that may involve more than one step, having difficulties manipulating information in mind, having a short attention span, and forgetting instructions easily.

On the plan/organize scale, there was a clinically significant elevation (T=71, 98th percentile). He reported some difficulties anticipating future events, setting goals, and developing appropriate sequential steps ahead of time in order to carry out a task or activity. He is likely to get overwhelmed by large tasks, has difficulty prioritizing activities, he may start the task without the right materials, and he does not plan ahead for future activities. He may have good ideas, but he cannot put them on paper. He may have unrealistic goals and problems organizing activities in his work.

On a task monitor scale, there was a clinically significant elevation (T=66, 99th percentile). He reported having difficulties with keeping track of projects or making careless mistakes.

Adaptive Functioning

Mr. Smith was administered the Independent Living Scales, which is an individually administered assessment of adaptive functioning and assessment of instrumental activities of daily living. The test has been standardized with both individuals who have neurological disorders or head injuries, for example, as well as dementia and borderline executive functioning and mild mental retardation. Mr. Smith overall scored a full scale standard score of 59. The borderline IQ standardized samples average was 78.4 while the mild mentally retarded group average mean score was 57.4. His overall score would be more in line with the mild mentally retarded group average.

On the memory/orientation domain, this task assesses an individual's general awareness of their surroundings and assesses short-term memory. Results include a standard score of 36 and the mild mentally retarded group average was 37.5, while the borderline IQ average was 48.8.

On the managing money domain assessing an individual's ability to count money and do monetary calculations, pay bills, and take precautions with money, Mr. Smith had a standard score of 20 and the mild mentally retarded group average score was 22.5 and the borderline IQ average was 32.2.

On the managing home and transportation domain assessing his ability to use a telephone, utilize public transportation, and maintain a safe home, he scored a standard score of 29. The mild mentally retarded group average was 23.7, while the borderline IQ average was 39.1.

On the health and safety domain assessing his ability to recognize and identify health and safety

needs and identify precautions to deal with health and safety needs, he scored a standard score of 42. The mild mentally retarded group average was 22.6 and the borderline IQ average was 36.5.

On the social adjustment scale assessing his thoughts and feelings about issues related to self-esteem and social life and importance of having friends, he scored a standard score of 20. The mild mentally retarded group average was 36.4, while the borderline IQ average was 41.3.

On the problem solving domain assessing his knowledge of relevant facts, as well as his ability to do abstract reasoning and problem solving, he scored a standard score of 26. The mild mentally retarded average was 20.8 and the borderline IQ average score was 34.2.

On the performance/information domain assessing general knowledge, short-term memory, and ability to perform simple everyday tasks, he scored a standard score of 32. The mild mentally retarded group average was 24.1, while the borderline IQ average was 39.5.

Overall, again, Mr. Smith's full scale standard score was 59, more in line with the mild mentally retarded group mean score average and intellectually disabled quality of functioning.

Emotional Functioning / Social Cognition

Mr. Smith was administered the Green's Emotional Perception Test (EPT), which is a brief test assessing the ability to judge emotion in tone of voice of tape recorded sentences. The EPT is significantly affected by both severe closed head injury and by various neurological diseases. The test is also correlated with intelligence. The authors indicate a cutoff score of 19

and greater is indicative of significant impairment. Mr. Smith had 34 errors, which indicated significant impairment.

Mr. Smith was administered the ACS Social Cognition Test. Social cognition skills may be impaired in a number of neurological, psychiatric, and developmental conditions including intellectual disability. Social perception measures skills associated with comprehension of social communication. Social perception items measure facial affect recognition and naming, affect recognition from processing facial expression, and affect recognition from processing interacting pairs of people. Performance on social perception tasks provides insight into an individual's deficits in social functioning.

For affect naming, the examinee uses photographs of faces and selects an emotion to describe the effect of the person in the photograph. For prosody-face matching, the examinee selects a face that matches the emotion expressed by a speaker. For prosody-pair matching, the examinee selects a photograph of interacting pairs of individuals to match a statement made by a speaker and interprets the meaning of the speaker's statement in light of the emotional context.

In this case, Mr. Smith had significant impairments relevant to social perception and cognition. His overall social perception score was mildly impaired (ss=6, 9th percentile). Affect naming, which is a simpler emotional processing task, was average (ss=11, 63rd percentile). However, social perception prosody and social perception pairs were severely impairment (ss=3, 1st percentile).

Motor Functioning

Mr. Smith was administered the Grooved Pegboard Test to assess for manual dexterity. His dominant right

hand score was mildly to moderate impaired (T=33), while nondominant left hand performance was mildly impaired (T=36).

Effort

Mr. Smith was administered the Test of Memory Malingering to assess for cognitive effort. He scored 40/50 on Trial 1, 45/50 on Trial 2, and 46/50 on Trial 3. Results indicated good cognitive effort.

CURRENT MENTAL STATUS/BEHAVIORAL OBSERVATIONS:

Mr. Smith is a 45-year-old single Caucasian male. He arrived for the interviews dressed appropriately. He displayed adequate hygiene and grooming. He was not always correctly oriented in all spheres. He knew where he was and he knew his name, but he did not always know the date. His verbal skills were very low. He presented as having difficulty understanding some of the words I used. He would laugh at times and act somewhat silly and younger than his age. His affect at times was constricted, and then it varied to normal in range. He got easily frustrated at times and did not always want to engage in my testing. He was easily distracted. He constantly looked around during the examination. He had to be redirected and refocused. Short-term memory was deficient as was vocabulary and comprehension of verbal information. His thought processes were lucid, clear, and goal directed without evidence of psychosis. He denied hallucinations or delusions. There was no evidence of internal preoccupation. He was consciously alert, but again had difficulties with sustained attention and was easily distracted. He often would shake his legs and head and was hyper-motoric. He reported at times some symptoms of depression that were described as mild in

nature. He denied symptoms related to psychosis, major depression, anxiety, PTSD, or mania. He denied current suicidal or homicidal ideation, plan, or intent.

CLINICAL DEFINITION OF MENTAL RETARDATION/INTELLECTUAL DISABILITY (AAIDD and APA DSM-5):

The American Association on Mental Retardation (AAMR) now called the American Association on Intellectual and Developmental Disabilities (AAIDD) (*Intellectual disability: Definition, classification, and system of supports* (11th Ed.).), defines Intellectual Disability as:

"Characterized by significant limitations of both intellectual functioning and adaptive behaviors expressed in conceptual, social and practical adaptive skills. The disability originates before age 18."

The following five assumptions are essential to the application of this definition.

1. Limitations of 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's intellectual disability generally will improve.

The definition includes that intellectual disability comprises significant limitations in both intellectual functioning and adaptive behavior as expressed in *conceptual, social,* and *practical* adaptive skill areas. The disability originates before the age of 18. Intellectual Disability refers to a particular state of functioning that begins in childhood, has many dimensions, and is affected positively by individual supports. The disability includes a context and environment within which a person functions and interacts. It requires a multidimensional and ecological approach that reflects the interaction of the individual with the environment and the outcomes of that interaction with regard to independence, relationships, societal contributions, participation in school and community, and personal wellbeing. The AAIDD is regarded as the leading mental health organization on mental retardation. It currently defines intellectual disability as a disability that is "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

The deficits in the intellectual functioning prong mean "approximately two standard deviations below the mean, considering the standard error of measurement for the specific assessment instruments used and the strengths and limitations of the instruments." The definition does not include an intelligent quotient (IQ) cutoff. Indeed, the AAIDD specifies that "the intent of this definition is not to specify a hard and fast cutoff point/score for meeting the significant limitations in intellectual functioning criterion. Rather, one needs to use clinical judgment."

Intelligence testing is only one aspect in determining intellectual disability. Significant limitations in

adaptive behavior and evidence that a disability was present before age 18 are elements that are important in determining whether a person is intellectually disabled.

Adaptive behavior is the collection of conceptual, social and practical skills that people have learned so that they can function in everyday life. Significant limitations in adaptive behavior can affect a person's life and their ability to respond to situations in their environment. Limitations in adaptive behavior can be determined by using standardized tests that are normed on a general population including people with disabilities and people without disabilities. Significant limitations in adaptive behavior are operationally defined as performance that is at least two standard deviations below the mean for one of the three following three types of adaptive behaviors:

1) conceptual

2) social

3) practical

(or an overall score on a standardized measure of conceptual, social, and practical skills).

It should be noted that pursuant to the AAIDD requirements, *conceptual adaptive skills* include language and literacy, money, time, and number concepts, and self-direction. *Social adaptive skills* include interpersonal skills, social responsibility, self-esteem, gullibility, naïveté, social problem solving, and the ability to follow rules/obey laws and to avoid being victimized. *Practical adaptive skills* include activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone.

The AAIDD defines intelligence as a general mental ability that includes one's ability to "make sense of things," "comprehend surroundings," "organize," "understand complex ideas," "to learn from experience," and "to engage in various forms of reasoning." Further, the AAIDD refers to the World Health Organization's definition of intellectual functioning including "general mental functions required to understand and constructively integrate the various mental functions, including all cognitive functions and their development over the life span."

APA DSM 5

American Psychiatric Association *Diagnostic and statistical manual of mental disorders (5th ed.)* Intellectual disability is defined in the DSM-5 as a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. The following three criteria must be met:

A. Deficits in intellectual functioning such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from previous experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that result in failure to meet developmental social and cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work and community.

C. Onset of intellectual adaptive deficits during the developmental period.

The DSM-5 discusses that intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound test of intelligence. Individuals with intellectual disabilities have scores approximately two standard deviations or below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-70 (70 plus/minus 5). Clinical training and judgment and required to interpret test results and assess intellectual performance. Factors that may affect test scores include practice effects and the "Flynn effect." The Flynn effect includes overly high scores due to out of date test norms. IQ test scores are approximations of conceptual functioning, but may be insufficient to assess reasoning in real life situations and mastery of practical tasks.

Deficits in adaptive functioning refer to how well a person meets community standards of personal independence and social responsible, and comparison of others of a similar age and social cultural background. Adaptive functioning involves adaptive reasoning in three domains: Conceptual, social and practical. The conceptual academic domain includes competency in language, memory, reading, writing, math, reasoning, acquisition of practical knowledge, problem solving, and judgment in all situations, among others. The social domain involves awareness of others' thoughts, feelings and experiences; empathy; interpersonal communication skills; friendship abilities; social judgment, among others. The practical domain involves learning and self-management across life settings including personal care, job responsibilities, money management, recreation, self-management of behavior, school and work and task organization, among others.

Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, culture experience and a coexisting general medical condition or mental disorder influence adaptive functioning.

Adaptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures. Standardized measures ideally should be used with knowledgeable informants such as a parent or other family member, teacher or counselor or care provider, and the individual if possible. Relying on an examinee's self-report may be unreliable due to a tendency to exaggerate abilities. Additional sources of information include educational, developmental, medical and mental health evaluations. Scores from standardized measures and interview sources must be interpreted using clinical judgment.

Criterion B is met relevant to adaptive functioning when at least one domain of adaptive functioning (conceptual, social or practical) is sufficiently impaired that ongoing support is needed in order to person to perform adequately in one or more of the life settings at school, at work, at home or in the community. To meet diagnostic criteria for an intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in criteria A.

Criterion C onset during the developmental period, refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence. All criteria, including criteria C, must be fulfilled by history or current presentation.

PAST RECORDS RELEVANT TO INTELLECTUAL DISABILITY FOR MR. SMITH:

There are school records regarding evidence pertaining to intellectual disability for Mr. Smith. They will be highlighted below.

- He was in third grade with assessment at Baldwin County Schools. The reason for referral was being an underachiever. He also had emotional factors. In first grade, he covered all readers and passed all tests, and he was marked ready for second grade. In the second grade, he made no progress. Nothing was marked on his reading card. In the third grade, he needed help functioning at grade 1 level. In the third grade, he had reading skills at 1.3 level, math at 2.1, and language at 0.1. He was, therefore, at least two grades below in reading and language.
- Baldwin County School records dated 01/30/1979 indicated to the parent in a letter from the school that they planned on having a specialist in the school to assess and evaluate the educational intellectual potentials of some of the students, including Joseph Clinton Smith. The principal believed that he would profit from an evaluation of this nature.
- There was a psychometric evaluation from Stapleton School dated 02/06/1979, grade three, with a Full Scale IQ of 75, verbal IQ of 80, and a performance IQ of 75. He was administered the WISC-R. He had the following scores: Verbal Subtests: Information, 4; Similarities, 9; Arithmetic, 7; Vocabulary, 7; Comprehension, 7; Digit Span, 11; Performance Subtests: Picture

Completion, 3; Picture Arrangement, 6; Block Design, 10; Object Assembly, 6; Coding, 3.

Mr. Smith was described as being an underachiever. There were emotional problems that may have been related to his lack of progress. He was found to give up easily. His effort varied on the nature of the task. He did give good cooperation and rapport.

Academic achievement testing included reading skills at the 1 year 7 grade level, standard score of 74, 4th percentile. Spelling included a 1 year 8 month grade level, standard score of 80 and 9th percentile, while arithmetic included a 3 grade level, standard score of 96 and 39th percentile. Further evaluation was suggested for Mr. Smith in order to determine if learning disability class placement was appropriate.

There were a number of recommendations noted by the psychometrist that would be related to adaptive functioning issues. He needed a lot of encouragement. He needed to have enthusiasm inspired. He needed for staff to describe objects and animals and have the children name correctly the item the teacher has in mind. Abstract reasoning development was important, such as assigning the children tasks appropriate to age level, such as questions of "what to do if...?" situations. It required the child to give explanations to such questions, such as, "Why do we wear clothes?" They would read simple nursery rhymes or fairy tales to the child and help discuss the meaning conveyed in the story. They would require the child to follow verbal directions. They would discuss the need and reasons for obeying safety rules, both at

home and at school. They would help the child to realize the need for respecting the rights of other. Good social conduct should be stressed. They would utilize hidden picture activities, such as those found in Highlights for Children. They would provide opportunities for the child to discriminate visual form in parts using puzzles, games, and color forms. They would encourage leisure time activities, such as crossword puzzles and pattern cards. They would utilize group activities which incorporate training and spatial relationships. They would utilize number-to-number coloring books and dot-to-dot pictures and model building activities. They would have one child begin a story and another child continue it using imagination and oral gauge. They arrange months of the year, days of the week, in order from a scrambled array. They would utilize visual, auditory, and tactile-kinesthetic approaches to reinforce verbal learning ties. They reproduced bead, block, and objects designs or patterns progressing from simple to complex tasks.

- A teacher observation form indicated that Mr. Smith would not stay on task and kept getting up and talking to boys and staring at the teacher and kept pointing at the teacher and laughing with the two boys. He was said to interact well with peers, but he had to be calmed down by teachers for talking too low and then high pitches and persistently telling the teacher how ugly she is.
- There was a Walker Problem Behavior Identification Checklist, Grade Four, dated 09/24/1979

filled out by his teacher. There was evidence of definite emotional handicaps. He had a total score of 43 compared to the male mean score of 22. He had deviations in every area except withdrawal, and there were highly significant scores in acting out. There were elevations on the distractibility scale and disturbed relationship scale, as well as immature scale. This again shows evidence of problems with social skills relevant to adaptive behavior functioning.

- Placement Committee Report, Grade Four, dated 10/17/1979 indicated that Mr. Smith read well on one task and worked on a second grade level in arithmetic and could not multiply or divide. He had half the fourth grade spelling list and did well, but he could not do skills. His handwriting included copying well, but he could not read cursive or write in cursive independently. His hearing was satisfactory and vision was 20/30 for right and left eyes. His social behavior included problems with acting out and feeling that others were picking on him.
- Baldwin School Service Plans included IEP meeting on 10/22/1979. He was functioning in the borderline range of average intelligence. He was emotionally handicapped in all areas except for withdrawal. He had particular problems in acting out behavior. He told the teacher that he did not want to do work and completed little work and was functioning below grade level in all areas. He had special problems in reading. Recommendations include checklist, token reinforcement, behavioral management techniques, and teacher-made materials.

- There were KeyMath Diagnostic Arithmetic Test scores available. He was in grade 4.2, as of 10/29/1979, with a grade equivalent of 4.0.
- There was an Implementation Plan IEP, grade 5, age 10, from Baldwin County Public Schools. He needed behavioral management techniques.
- Mr. Smith was evaluated with the Peabody Individual Achievement Test on 04/27/1981, age of 10 years 9 months. Mathematics score was 5.7 grade equivalent, reading recognition was 2.8 grade equivalent, reading comprehension was 3.1 grade equivalent, spelling was 2.9 grade equivalent, general information was 2.7 grade equivalent, and total test was 3.1 grade equivalent. He was in the 5th grade at that time, and was therefore functioning two grades below his grade placement.
- Alabama Individualized Education Program dated 05/06/1981, fifth grade, from Baldwin County Public Schools indicated that he was acting out and was distractible in all areas. His behavior rating on a social maturity scale was two to three grades below expectation of the fifth grade. On 04/27/1981, in grade five, he was administered the PIAT. His strength was in areas of mathematics at 5.7 grade level. Reading recognition was at 2.8 GE, reading comprehension was at 3.1 GE, spelling was at 2.9 GE, general information was at 2.7 GE, and his total test battery was 3.1. He was about two grades below expectation grade level overall in academic subjects. Letter identification was at 6.2 GE, which was a strength for him. However, word identification was at 2.1 GE, word attack was 2.9 GE, verbal comprehension was 3.0 GE,

passage comprehension was 2.8 GE, and his overall testing battery was 3.8 GE, one or two grades below expectation grade level.

- Baldwin County Public Schools records dated 05/1981, grade 5, IEP, indicated behavioral problems. He had difficulty sitting quietly. He had difficulty completing assignments.

- Alabama IEP records dated 1981-1982 from Stapleton Elementary School indicated that the teachers had concerns about his reading level. The goal for Jody's reading skills was to increase his reading to a 3.0 grade level. At the time he was in the fifth grade.

  There was a request for parental permission to evaluate Mr. Smith dated 11/05/1982, from Baldwin County School System and E. Kranz/teacher for assessment of emotional factors. They wanted to assess him fully for maturity, speech and vision, IQ, behavioral scales, and motor development.

- Baldwin County School, dated 12/02/1982, included an Individual Intellectual Assessment report. He was in grade six with a calculated age of 12 years 4 months and a mental age of 9 years 1 month. His Full Scale IQ was 74, verbal IQ of 80, and performance IQ of 72. His IQ scores include the following verbal subtests: Information, 5; Similarities, 7; Arithmetic, 8; Vocabulary, 6; Comprehension, 8; Digit Span, 11. Performance IQ Scores: Picture Completion, 5; Picture Arrangement, 5; Block Design, 7; Object Assembly, 5; Coding, 7. He was currently repeating the sixth grade. He had changed schools seven times in seven years of school

attendance. He was currently enrolled in the EC program at Spanish Fort School. His teacher reported Jodi seldom completed work, fails to follow directions, and is aggressive and hostile.

Therefore, in addition to an IQ that is potentially in an intellectually disabled range, these records are important to stress his adaptive functioning deficit germane to following directions, social skills, anger, hostility, etc. While he was in the sixth grade, his scores on the Wide Range Achievement Test (WRAT) included reading standard score of 81, 10th percentile, 4.5 GE; spelling skills standard score of 73, 4th percentile, 3.6 GE; and arithmetic scores standard score of 76, 5th percentile, 3.9 GE. On the Peabody Picture Vocabulary Test, chronical age was 12 years 5 months and he had a standard score of 73, 4th percentile, and age equivalent 8 years 3 months.

- Alabama Basic Competency Test Writing Section, grade six, from Monroeville Middle School included adequate writing skills except for capitalization. His sentences were complete, topic sentences were supported and developed by three or more sentences, sentences were grammatically correct, spelling and punctuation were correct, and handwriting was legible.
- I did review some of his grades, and they were a mixture between failures and As, Bs, Cs, Ds, and Fs. His As appear to be for physical education with poor grades in the all standard areas of English, reading, mathematics, science, and social studies.

- Monroe County Board of Educational Exceptional Child Services Eligibility report dated 03/08/1983 included him being in the sixth-grade level. Educational alternative recommended was regular classes.
- Alabama State Testing Program Individual Student Profile California Achievement Test, age 12 years 9 months, dated April 1983, included records that were hard to read because of the print quality. Vocabulary was in the 12th national percentile, comprehension was in the 4th percentile, reading was in the 3rd percentile, spelling was in the 2nd percentile, language mechanics was in the 10th percentile, language expression was in the 21st percentile, overall language was 14th percentile, math computation was in the 18th percentile, math concepts/applications was 16th percentile, and total mathematics was 16th percentile. Overall battery was in the 6th percentile.
- Monroeville Junior High School records dated 10/26/1983 included a letter by the principal to Jodi Smith's mother. The principal stated Jodi had been a constant behavioral problem, especially on the school bus, during the entire school term. He was the first seventh grader that the principal had to learn by name this year. He made himself known at the bus loading area during the first days of school while the principal was supervising bus loading. This morning, he had been involved with some other students on the bus because he did a lot of cursing in the principal's presence when he got off the bus. He told the principal another student had cursed him and he was cursing

him, but the principal only heard Mr. Smith. Because of his continued misbehavior and complete disrespect for the principal, the principal suspended him for five days. The principal urged the mother to have him understand the behavior at school and the bus must conform with acceptable standards.

- IEP records in 1982-1983 indicated continued behavioral problems and needing teacher's attention in class. He also was physically aggressive at times.
- School records dated 03/05/1984 included student withdrawal form grade 7. Number of days enrolled were 121. Number of days present was 112. Tardy was zero. Reason for withdrawal was moving. He had the grade of F for English. Social studies grades were S and D. Math were S and D. Science were S and D. Physical education was A, B, and C. Basic skills were B, C, and D. It should be noted that the major classes, such as English, social studies, math, and science were for the most part more difficult classes and were usually all Fs.
- Monroe County Board of Education Eligibility Report and Exceptional Child Services records dated 03/09/1984 from Excel School placed him at grade placement of seven and included educable mentally retarded exceptionality errors. The educational alternative recommendation was regular classes with resource room services.
- KeyMath Diagnostic Arithmetic Test from Excel Public School dated 04/16/1984 included mathematic scores of 5.8 grade equivalent.

- Monroe County Public Schools records dated 05/18/1984 (8th grade) IEP had goals of improving reading levels to fifth grade, improving math levels to 6.8 grade level, and improving language skills to 6.0 level.
- There were secondary school records from the Excel Public School. His grades from 1983 to 1984 included all Fs and Ds, for the most part, which was the same type of performance for 1984 and 1985. At that time, he was in junior high school and 13 to 15 years of age.
- As of April 1985, the IEP records indicated a goal of improving reading to 5.0.
- There was a Stanford Achievement Test with Otis-Lennon School Ability Test dated 04/1985, age 14 years 9 months. These scores indicated significant impairments. His National Percentile Rank included the following: Reading comprehension, 2nd percentile; vocabulary, 3rd percentile; listening and comprehension, 2nd percentile; spelling, 3rd percentile; language, 1st percentile; concepts of number, 21st percentile; math computation, 9th percentile; math applications, 7th percentile; social science, 7th percentile; science, 1st percentile; using information, 3rd percentile; total listening, 2nd percentile; total language, 1st percentile; total mathematics, 10th percentile; basic battery total, 3rd percentile; complete battery total, 3rd percentile; and Otis-Lennon School Ability Test, 4th percentile.

  It is my opinion these scores would be consistent with an intellectual disability. He was below average for most areas of testing regarding reading comprehension, vocabulary, listening

comprehension, spelling, language, concepts of numbers, mathematics computation, mathematics applications, social science, science, and using information.

- Excel Public School records, grade 8, included numbers of days present were 140 and unexcused absences were seven days. There was evidence of special education. His grades were a mixtures of Bs, Cs, Ds, and Fs.
- There were assessment results concerning prior psychological evaluation dated 08/28/1998 (pretrial evaluation for instant offense) by Dr. James Chudy. Mr. Smith was 28 years of age at the time. WRAT-3 academic achievement scores included a reading standard score of 69, 2nd percentile, 4th grade equivalent; spelling standard score of 63, 1st percentile, 3rd grade equivalent; and arithmetic standard score of less than 45, 0.2 percentile, kindergarten grade equivalent. These scores are consistent with functioning in the intellectual disability range.

  During this same examination, on 08/28/1998, Mr. Smith was administered the WAIS-R to assess for Full Scale IQ. His effort and persistence were appropriate. His attitude seemed good. His concentration seemed appropriate. He had a Full Scale IQ of 72, verbal IQ of 73, and performance IQ of 72. His verbal subtest included an information scale score of 3, digit span of 7, vocabulary of 5, arithmetic of 5, comprehension of 5, and similarities of 6. Performance test included a picture completion score of 4, picture arrangement of 5, block design of 6, object assembly of 8, and digit symbol of 4.

The WAIS-R was standardized in 1978. There was a Flynn effect regarding the WAIS- R test in 1998. The "Flynn effect" refers to the observed rise in IQ scores over time, resulting in norms obsolescence. The Flynn effect analysis would include the following: 1998-1978= 20 x 0.333 = 6.66. Therefore, Mr. Smith's Full Scale IQ would be modified from 72 to about 65.4.

Dr. Chudy noted that there were issues with Mr. Smith's concentration, being distractible, preoccupied and inattentive during evaluation. He was indecisive and ambivalent with poor problem solving and judgment skills. There was evidence of mild levels of mental confusion reported. Testing showed that he had levels of depression which needed further mental health treatment if they were clinically present and were not due to substance abuse, withdrawal, or malingering. The test scores may indicate major depression or may represent an adjustment disorder. He had difficulties dealing with everyday stress and he worried and had physical symptoms of over-arousal. Personality functioning included evidence of stormy relationships described as hostile dependent and intensive isolation and loneliness. There was some evidence of schizotypal personality features. Testing indicated evidence of schizoid avoidant and dependent personality features.

It should be noted that Mr. Smith had a score within the mild intellectual disability and mild mental retardation range, but he was not examined for a full intellectual disability evaluation pertaining to collection of adaptive

functioning information and testing from collateral informants and/or assessment of Mr. Smith one on one for adaptive functioning.

The psychological report by Dr. Chudy indicated that the mother claimed her son started getting into trouble at school, he was extremely frustrated in school, and he was failing most subjects. The family also moved every year. He became increasingly angrier that he had to repeatedly adjust to new schools and sometimes to more than one school in a year. His learning problems coupled with being in emotionally conflicted classes left him feeling embarrassed when he started each new school. He eventually quit all efforts toward making friends because he knew eventually he would be moving away and would have to separate from them. He spent much of his early adolescence as a loner doing poorly in school without developing a sense of competence or mastering either academics or making friends. As he got older, his frustration became more evident. He was volatile at home, but never physically abusive toward any of his family, but he continued to violate family rules and would act out. He eventually used and abused alcohol. There was evidence of a chronic state of anxiety with extreme difficulty sleeping. He also had been struck on the head on numerous occasions and lost consciousness several times.

As noted, he scored a Full Scale IQ of 72, which was not Flynn effect analyzed at the time of trial. Dr. Chudy stated that he qualified for borderline range of intelligence. Dr. Chudy, in my opinion, once getting an IQ of 72 and

academic achievement scores within the intellectually disabled range including 69 for reading, 63 for spelling, and 45 for arithmetic, should have conducted further assessment as global academic achievement testing impairments consistent with intellectual disability and an IQ in that range would require further adaptive testing and developmental assessment of intellectual disability.

As noted, there was evidence that he had experienced suicidal ideations and depression, as well as anxiety. He diagnosed Mr. Smith with major depression, severe without psychotic features, PTSD due to early childhood trauma, alcohol dependence, learning disorder, personality disorder with schizotypal and antisocial features, and borderline intellectual functioning. A full mental retardation/intellectual disability assessment was not conducted.

- There was a direct examination for the trial by witness Glenda K. Smith. Ms. Smith was Jodi Smith's mother. In her testimony, she did note that he attended school through the 7th or 8th grade. She noted that he attended about seven schools due to moving around. She acknowledged him having special education problems including dyslexia and special education. He was in emotional conflicts placement.

ASSESSMENT OF INTELLECTUAL FUNCTIONING FOR MR. SMITH:

Understanding and application of what has been called the Flynn Effect named after the New Zealand scholar who first described the phenomenon of intellectual functioning norms becoming less stringent

over time, is recommended in the AAIDD *User's Guides*. The Flynn Effect means that the normative standards (norms) for measures of intelligence become less stringent over time at the rate of approximately 0.3 points per year. For example, if the norms for an intelligence test are 10 years old, the population mean on the test no longer is 100, but 103 [100 + (0.3)(10)]. Moreover, the point that is two standard deviations below the mean is no longer is 70, but 73 (assuming a mean of 100 and standard deviation of 15). Recent comprehensive meta-analyses based on hundreds of empirical articles were published in high quality journals, providing strong support for the existence of the Flynn Effect and the correction for the obsolescence of norms using the 0.3 points per year.

Past IQ Testing

In this case, Mr. Smith does have prior intellectual assessment and IQ testing.

- Mr. Smith was evaluated in the third grade at Stapleton School on 02/06/1979 with a Full Scale WISC-R of 75 with verbal IQ of 80 and performance IQ of 73. It is important to note the Flynn effect when considering the prior IQ score on the WISC-R. The WISC-R was published in 1974 but normed in 1972. 1979-1972=7 x 0.333=2.33, 75- 2.33 =72.67, which would be the adjusted Flynn effect IQ score.
- Baldwin County School records dated 12/02/1982, included an Individual Intellectual Assessment report. He was in grade six with a calculated age of 12 years 4 months and a mental age of 9 years 1 month. When considering the Flynn effect, he was again administered the WISC-R, and the year was in

1982. The Flynn effect includes the following analysis: 1982- 1974= 8 x 0.33= 2.66. 74-2.66= 71.4. His Full Scale IQ score when considering the Flynn effect would be approximately 71.4.

- There was an administration of the WAIS-R in 1998. He had a Full Scale IQ of 72, verbal IQ of 73, and a performance IQ of 72. There was a Flynn effect regarding the WAIS-R test in 1998. It my understanding that the WAIS-R was standardized in 1978. The Flynn effect analysis would include the following: 1998- 1978 = 20 x 0.333 = 6.66. 72-6.66 = 65.4.

In summary, Mr. Smith has had three prior IQ administrations. Two assessments were during the developmental period. On 02/06/1979, he was about 9 years 5 months of age. He had a Full Scale IQ on the WISC-R of 75. When concerning the Flynn effect, his score would be about 73.4.

On 12/02/1982, at age 12 years 4 months, he had a Full Scale IQ on the WISC-R of 74, verbal IQ of 80, and performance IQ of 72, with a Flynn effect adjusted score of about 71.4. In 1998, he had a Full Scale IQ on the WAIS-R of 72 and with a Flynn effect adjusted score, his IQ would be 65.4.

Some of his past IQ scores were in the intellectual disability or potentially in the range, given the Flynn effect and the standard error of measurement.

Current IQ Testing

In my evaluation of Mr. Smith, I administered the Stanford-Binet Intelligence Scale, Fifth Edition.

He had a Full Scale IQ of 78, with a nonverbal IQ score of 75 and a verbal IQ of 83. His IQ is above the intellectually disabled range based on AAIDD

standards, but the DSM-5 and AAIDD also consider intellectual functioning as measured more broadly considering deficits in reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from previous experience, confirmed by both clinical assessment and individualized, standardized intelligence testing (DSM-5 criteria).

The Stanford-Binet, Fifth Edition, was normed in 2001. The Flynn effect would include the following analysis: Year 2014-2001= 13 x .333 = 4.3. His score would be adjusted for the Flynn effect from a 78 to a 73.7.

ASSESSMENT OF ADAPTIVE FUNCTIONING FOR MR. SMITH:

Past Academic Achievement Assessment (Conceptual Adaptive Skills)

According to the AAIDD, conceptual adaptive skills include literacy, self-direction, and concepts of number, money and time. The prior records outlined pertaining to academic achievement functioning during his school years suggest that Mr. Smith had often functioned at least two grade levels below his grade placement in a number of academic areas. He had special education and IEP placements. He demonstrated academic achievement deficits with both psychological testing and national standardized school based testing (See past records relevant to intellectual disability above).

It should be noted that there were a number of qualitative records for Mr. Smith regarding academic achievement and success/failure in school. He struggled in the 2nd grade making no progress. In the 3rd grade, he had reading skills at the 1st grade level and language skills below the 1st grade level. He was there for at least two grades below in reading and language at that time.

By 9 years of age, the school principal was concerned about Mr. Smith's academic success and planned on having a specialist evaluate his educational and intellectual potential. In 1979, he continued to have difficulties with attention and would get up out of his chair and instigate with other youth.

School records from 1981, when he was in 5th grade and approximately 10 years and 10 months of age, indicated he continued to struggle with academic subjects and his overall grade equivalent test battery was about 3.8, one or two grades below actual grade level. In 1981-1982, the Alabama IEP records indicate he was reading at a 3rd grade level despite being in the 5th grade.

In 1983, at age 12 years 9 months, his overall individual student profile California Achievement Test results were in the 6th percentile.

The 1984 records at approximate age 14 indicated he was reading around the 5th grade level when he was in about the 8th grade. Language skills were in the 6th grade level and math skills were in the 6.8 grade level. He continued to perform below grade level. Around that time, age 14 years of age, he was performing at the 5.8 mathematics grade equivalent.

In 1985, he was also reading around the 5th grade level pursuant to IEP records. By age 14 years 9 months, in 1985, he struggled in a number of areas on the Stanford Achievement Test pertaining to reading comprehension, vocabulary, listening comprehension, spelling, concepts of number and math computation, math applications, science, and social science. His basic battery total was around the 3rd percentile.

In 1987, records around 10 years 9 months, indicate that he was struggling with reading recognition,

reading comprehension, general information, and was functioning overall academically at the 3rd grade level when he was in the 5th grade.

For pretrial purposes, he was evaluated by another psychologist with WRAT-3 academic achievement scores. He had reading score of 69, spelling score of 63, and arithmetic score of 45. These scores were consistent with functioning in the intellectual disability range.

Past Social Adaptive Skills

Mr. Smith's background academic records indicate a consistent history of social skill deficits. He needed a lot of encouragement. He had difficulties with behaviors and would instigate other students. He had difficulty staying on task. He had to calm his behavior down. His social behavior included problems with acting out and feeling that others were picking on him. He was very distractible. The school evidence showed behavioral problems and social skill deficits. Recommendations at age 9 years included token reinforcement and behavioral management techniques for example. Numerous records outline behavioral management techniques that were needed.

He was evaluated in 1982, at about 12 years of age, with behavioral scales. He continued to have behavioral problems and needing the teacher's attention in class. He was also physically aggressive.

Mr. Smith's mother reported that he had a history of special education. He had difficulties with relationships with peers and was picked on. He was extremely frustrated in school and was failing most classes. He had difficulty with low frustration tolerance and anger. Learning problems coupled with emotionally conflicted classes in special education caused him some embarrassment and feelings related to peer rejection.

He also had evidence of suicidal ideation and depression, as well as anxiety, poor coping skills, and use of substances to deal with these issues.

Past Adaptive Functioning Assessment

Mr. Smith never was evaluated during his school years with a formal adaptive functioning assessment, including objective assessment with a collateral information, such as his mother or a teacher.

Current Academic Achievement Assessment (Conceptual Adaptive Functioning)

During my current assessment, Mr. Smith was administered the Woodcock-Johnson Test of Academic Achievement, Third Edition. He performed above expectation in the below average range. His overall achievement was standard score of 87 and 7th grade level, 12 years 5 months age equivalent. Letter-word identification single word reading score was standard score of 89, reading comprehension was standard score of 96, while mathematic calculation skills were standard score of 84, mathematical applied problems were standard score 86, and spelling skills were standard score of 86.

These scores are mildly elevated when considering an ID claim. However, the 1998 adulthood pretrial academic achievement assessment records suggest WRAT-3 scores in the intellectually disabled range.

Current Social Skills Assessment

I did administer Mr. Smith the Social Cognition Test. He had significant impairments relevant to social perception and cognition. His performance on the Emotional Perception Test was also significantly impaired.

Current Adaptive Functioning Assessment

Mr. Smith was administered the Independent Living Scales (ILS), which is an individually administered assessment of adaptive functioning that I did with him examining assessment of instrumental activities of daily living. There are a number of scales on this task, but overall he had a full scale standard score of 59. When looking at the standardized samples on the ILS, his score is more consistent with the mild mentally retarded group average mean score of 57.4. His overall results would be consistent with current adaptive functioning in the intellectually disabled range.

Other Neuropsychological Assessment Impairments

The AAIDD also emphasizes more global neurocognitive and cognitive deficits in their definition of intelligence, including areas of memory and executive functioning. I did conduct further neuropsychological and cognitive functioning testing with Mr. Smith beyond the traditional IQ, academic achievement, and adaptive functioning assessments. He had significant impairments with immediate memory. Auditory comprehension also included significant impairments. Both receptive and expressive language skills were moderately to severely impaired. Verbal abstract reasoning executive functioning skills were mildly to moderately impaired. He had similar results on a category task assessing nonverbal abstract reasoning skills. Inhibition and impulse control skills on a color-word interference test were severely impaired. The results suggest significant evidence of frontal lobe dysfunction and potential brain damage in that area.

FORENSIC OPINION:

Ms. Kacey Keeton, Assistant Federal Public Defender, requested that I examine Mr. Smith for current forensic psychological and neuropsychological evaluation

and, in particular, as to whether he is intellectually disabled as well as to conduct further neuropsychological testing to examine his brain functioning.

The AAIDD and DSM-5 provide definitions and guidelines that we clinical and forensic mental health experts utilize when assessing intellectual disability. The definitions between the two organizations are very similar. Overall, when considering Mr. Smith's case, there is clear evidence that he experienced significant limitations in intellectual functioning and adaptive behaviors expressed in conceptual, social, and practical adaptive skills, both developmentally and before 18 years of age and in adulthood.

Mr. Smith was placed in special education classes and demonstrated significant conceptual deficits regarding academic achievement and standardized testing, as well as significant social adaptive skill deficits with early and consistent behavioral problems. The records in Mr. Smith's history and available collateral information outlined that he never had good meaningful social and intimate relationships with other people. He was suggestible and other people took advantage of him. He was described as a follower and never a leader. He would follow direction to fit in with others. Some of this following type of behavior would lead him into trouble, and he had difficulty appreciating consequences for his behaviors. His brain damage also led to difficulties not only appreciating consequences but in inhibiting behaviors. He continued having difficulties with school behavioral problems and would try to instigate other youth.

Mr. Smith never had academic success. Conceptual and academic skills included significant deficits related to special education needs and little to no progress in the 2nd grade. The committee report on Mr.

Smith stated he made no progress past the 5th grade. Around that time, his California Achievement scores show him reading at grade level of 1.3 and language skills at 0.1 grade level. During that year of 5th grade, he was functioning at a 3.1 grade equivalent. His grades were often about a D average. Around the 6th grade, school records indicated he had difficulty controlling impulses or desires, and he was doing very poor work in regular classroom, even though he was in low level classes. He had overall little, if any, success during his school years. The public schools he attended also consistently contacted his parents outlining his special needs and suggested programs that would be of benefit to him. He suffered from deficiencies in comprehension and reasoning. Importantly, the Monroe County Excel Junior High School Board of Education classified him as Educable Mentally Retarded (EMR) based on psychological and educational evaluations, academic history, and other pertinent information.

Intellectual assessment and academic achievement assessment both in childhood and adulthood are at times consistent with an intellectual disability. Adaptive functioning assessment in adulthood is consistent with intellectual disability. Therefore, importantly, there is evidence of clear functioning in the intellectually disabled range developmentally and in adulthood.

The AAIDD defines intelligence as a general mental ability and also includes functioning relevant to "understanding complex ideas," "engaging in various forms of reasoning," and ultimately the current neuro-psychological testing clearly highlights executive functioning, problem solving, abstract reasoning, as well as attention and memory problems.

The DSM-5 similarly elucidates examples of adaptive functioning deficits such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. These impairments are all confirmed by my clinical neuropsychological assessment as well as by prior academic records and reports by his mother and other collateral witnesses. These deficits in adaptive functioning are clearly relevant in compromising his ability to achieve personal independence and social responsibility.

It is my opinion with a reasonable degree of psychological and neuropsychological certainty that Mr. Joseph Smith is more likely than not an intellectually disabled individual and qualifies for intellectual disability, both developmentally and in adulthood.

Respectfully submitted,

John Matthew Fabian
/s/ John Matthew Fabian
e signature
John Matthew Fabian, PSY.D., J.D., ABPP
Board Certified Forensic & Clinical Psychologist Forensic & Clinical Neuropsychologist

EXPERT WITNESS REPORT OF
DR. DANIEL J. RESCHLY, Ph.D.
REGARDING JOSEPH C. SMITH
EXECUTIVE SUMMARY

1. I was contacted by Kacey L. Keeton, Assistant Federal Defender, to consider providing an expert opinion applying my expertise in mild intellectual disability, special education, and intellectual assessment to the case records in the Joseph C. Smith appeal of a death sentence related to a crime committed in November 1997. I reviewed available records (see list that appears below) and reached the following tentative conclusions. I did not meet Mr. Smith or collect any information in addition to the records reviewed.

2. Based on multiple evaluations Mr. Smith's current and prior intellectual functioning is at the critical level of approximately IQ equal to 65-75 in terms of functional intelligence as applied in everyday situations ([1]AAIDD, 2010; APA-DSM 5, 2013). This conclusion is based on reviewing records from his childhood, adolescence, and adult years.

3. Adaptive behavior deficits were apparent in Mr. Smith's everyday functioning, beginning in childhood and continuing into his adult years according to school and other records. The adaptive behavior deficits in

[1] The name of the leading international organization was changed in 2008 from the American Association on Mental Retardation to the American Association on Intellectual and Developmental Disabilities. As part of this change what formerly was called mental retardation has been changed to intellectual disability. DSM-5 also uses the term intellectual disability rather than mental retardation. The terms mental retardation and intellectual disability have equivalent meaning.

everyday performance were associated with significant limitations in functional or everyday intelligence.

4. Mr. Smith was a person with intellectual disability as a child and adolescent. I defer judgment about his adult status because I have not completed an independent evaluation.

5. These opinions and conclusions are subject to modification based on my review of any additional case material that might become available at a later date.

EXPERT WITNESS QUALIFICATIONS

6. My name is Daniel J. Reschly. I am a nationally certified school psychologist and expert in mild intellectual disability, located in Franklin, TN, a suburb of Nashville. I am Professor of Education and Psychology Emeritus at Peabody College, Vanderbilt University where I chaired the top ranked Department of Special Education in the U.S. from 1998-2006. I joined the Vanderbilt faculty in 1998. I was a professor in the Department of Psychology at Iowa State University from 1975 to 1998 where I also directed the school psychology program and achieved the rank of Distinguished Professor of Psychology (top 5% of ISU faculty). My teaching and research are focused on the identification, treatment, and outcomes for persons with mild intellectual disability and learning disabilities and analysis of disproportionate minority representation in various programs. I have a Ph.D. in School Psychology from the University of Oregon. I obtained my M.A. in School Psychology from the University of Iowa, and my B.S. from Iowa State University. My career as a college professor for 43 years was devoted to educating school psychologists and special education teachers, and to research on the identification and treatment of persons with disabilities.

7. The focus of my evaluation was to determine if Mr. Smith met the criteria for the intellectual disability (ID) diagnosis, utilizing information obtained from interviews and measures of intellectual and educational competencies as well as records from prior evaluations, mitigation interviews, and documents made available to me by defendant's counsel. All facts set forth in this report were based on my personal knowledge, research and analysis, conducted in accordance with the generally accepted norms of my profession.

8. I am a Nationally Certified School Psychologist (NCSP), National Association of School Psychologists Certificate #14126, and practiced as a school psychologist in Iowa, Oregon, and Arizona. My current status as an NCSP means that I meet the criteria for school psychology certification/licensure in 38 states (https://www.nasponline.org/standards-and-certification).

9. I have published over 100 articles, chapters, and books on the topics of mild intellectual disability, school psychology professional practices, and the assessment of disabilities in minority children and youth. I received a Lifetime Achievement Award and three Distinguished Service Awards from the National Association of School Psychologists, the Stroud Award, and was appointed to Fellow of the American Psychological Association and the American Psychological Society. I have substantial clinical experience diagnosing individuals with ID, including teaching and supervising students in making such diagnoses. I am not licensed as a psychologist in any state and I do not engage in private practice to provide individual or group treatment of mental disorders.

10. I taught in school psychology programs at the University of Arizona and Iowa State University where I was responsible for educating graduate

students in high incidence disabilities including mild intellectual disability, specific learning disability, and behavior disorders. I taught the classes on intellectual assessment to graduate students in the school and counseling graduate programs including specific instruction in the Wechsler preschool, children, and adult scales. As part of this instruction I was responsible for ensuring competence in administration, scoring, and interpretation of the Wechsler Adult Intelligence Scale and other commonly used measures as well as ensuring background knowledge in tests and measurement, statistics, intellectual theories and development, and cultural influences on intellectual performance. The determination of mild intellectual disability and specific learning disability were key competencies developed in these courses. Since joining the faculty at Vanderbilt University I have been responsible for teaching educational assessments, tests and measurements, and measures of social competencies and adaptive behavior.

11. My training, experience, and leadership in school psychology are especially relevant to the diagnosis of Mild Intellectual Disability since most such diagnoses are made first during the school-age years of 5-18. Initial diagnosis of more severe levels of ID usually occurs during the pre-school years, often at or soon after birth. In contrast, initial diagnosis of *Mild* ID typically is prompted by teacher referral due to chronic educational failure. The next step in the process is a comprehensive evaluation typically conducted by a school psychologist employed by a public school system. In fact, school psychologists make more diagnoses of mild ID than any other professionals including those in various specialties of psychology, education, and medicine.

12. In this case I am working as an expert in Mild Intellectual Disability based on my extensive experience and accomplishments with this diagnostic group. I have been accorded expert witness status and delivered testimony in state and federal courts on 25 cases regarding issues related to Mild Intellectual Disability and the identification of children and adults with disabilities. I provided evaluations and consultation to attorneys in an additional 30 cases that were settled prior to hearings or my findings did not agree with attorneys' approaches to the case. A list of cases appears in my *curriculum vitae* at pp. 45-47.

13. I chaired the National Academy of Science (NAS) Panel on Disability Determination in Mental Retardation, and co-edited the resulting report (Reschly, Myers, & Hartel, 2002), published as *"Mental Retardation: Determining Eligibility for Social Security Benefits."* (Washington DC: National Academy Press, 2002, http://www.nap.edu/catalog/10295.html?se_side). The Panel's report was designed to guide the Social Security Administration's decisions regarding eligibility for benefits due to ID for children, adolescents, and adults and, as part of that effort, it was called upon to review and interpret various definitions of ID. The NAS Panel ultimately adopted an ID definition that was highly influenced by the American Association on Mental Retardation Manual on Classification (Luckasson et al., 1992) with the exception that we identified fewer and more general adaptive behavior domains. Our approach to adaptive behavior preceded and likely influenced the AAMR/AAIDD (Luckasson et al., 2002; Schalock, et al., 2010) and APA-DSM 5 (2013) adoption of three broad domains of adaptive behavior in revisions of their classification manuals.

14. I also was a member of the National Academy panels on *Standards-Based Reform and the Education of Students with Disabilities* (report issued in 1997, see McDonnell, McLaughlin, & Morison, 1997) and *Minority Students in Special and Gifted Education* (report issued in 2002, see Donovan & Cross, 2002).

15. I served as an Administrative Law Judge in Iowa from 1988-1998, conducting hearings and deciding cases involving the provision of educational services to students with disabilities. In this role I interpreted and applied federal and state legal requirements in the resolution of cases. A list of cases is provided in my *curriculum vitae*

16. Attached is a copy of my *curriculum vitae,* which provides further details of my experience, list of publications, and legal cases in which I provided expert testimony at trial or deposition.

17. I was hired by counsel for Mr. Joseph Smith as an expert in intellectual disability, special education, and intellectual assessment.

DEFINING INTELLECTUAL DISABILITY (ID)

18. The conceptual definitions and classification criteria for intellectual disability (ID) have evolved over the last 100 years. An early and widely cited traditional ID definition was formulated by Doll (1941). This definition defined mental deficiency, an earlier term for ID, as social incompetence due to mental subnormality that is developmentally arrested, obtains at maturity, is of constitutional origin, and is essentially incurable. The key theme in this definition is social incompetence (an earlier term for adaptive behavior) that is related to low intellectual functioning. The condition must appear by maturity, although it may not be diagnosed until developmental maturity

has been attained. For example, evidence may exist in a variety of forms that an adult was a person with ID as a child, but for any one of a number of reasons, the ID condition may not have been identified until the adult years.

19. The American Association on Mental Retardation (AAMR), recently renamed as the American Association on Intellectual and Developmental Disabilities (AAIDD), is the authoritative international organization regarding definition and classification in mental retardation-intellectual disability (Reschly, 1992, 2013). The title of this organization was changed in 2008 to the American Association on Intellectual and Developmental Disabilities (AAIDD). In this report I use AAIDD to refer to official publications of the organization.

20. The AAIDD has published a definition and classification manual since 1916. The most recent revision is the 11th edition of this venerable and vital resource concerning ID (Schalock et al., 2010). Other organizations such as the American Psychiatric Association's (APA) (2000) Diagnostic and Statistical Manual of the Mental Disorders (4th Edition, Text Revision), APA-DSM 5 (2013) follow the AAIDD, rather than lead, changes in ID criteria (Reschly, 1992, 2013; Reschly et al., 2002). I note also that the United States Supreme Court quoted the 1992 AAIDD Classification Manual in *Atkins v. Virginia,* 536 U.S. 304 (2002). The decision in *Hall v Florida,* 134 US Supreme Court, 1986 (2014) cited DSM 5 and the 2010 11th ed of the AAIDD Classification Manual.

21. The AAIDD definitions, the APA-DSM IV-TR and DSM 5 definitions, and all existing ID definitions and classification criteria formulated in the last 50 years of which I am aware, establish a three-pronged diagnosis of ID; specifically, a) significant limitations

in intellectual functioning, previously stated as significantly subaverage general intellectual functioning, b) adaptive behavior deficits associated with significant limitations in intellectual functioning, and c) origins in the developmental period, now typically defined as before age 18 years.

22. The 2002 AAMR-AAIDD Classification Manual defined mental retardation as, "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." (Luckasson et al., 2002, p. 1).

23. The 2010 AAMR-AAIDD Classification Manual defined intellectual disability as, "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills." (Schalock et al., 2010, p. 1).

24. Although the name changed from mental retardation to intellectual disability, the definition of the latter clearly is grounded in the prior definitions of mental retardation. The terms mental retardation and intellectual disability have equivalent meanings in the AAMR-AAIDD Classification Manuals over the last 50 years.

25. The diagnosis of ID as formulated by the AAIDD refers to "... present functioning." Luckasson et al. (1992; 2002) and Schalock et al. (2010) clearly imply that a person may be validly classified ID at one point and not at another across the life span. It is required that evidence of ID appears during the developmental period typically defined as birth to the early adult years.

26. The dominance of the AAIDD in the determination of criteria for ID is clear from examining the official policies of professional and scientific organizations as well as educational and legal definitions of intellectual disability (Reschly et al., 2002). All state legal criteria I have reviewed use the 3-pronged criteria specified by AAIDD and APA-DSM 5, often with less description of the components of and criteria for intellectual functioning and adaptive behavior (See also Duvall &Morris, 2006). Therefore, in determining and interpreting the criteria for ID where specification is absent in existing statutory definitions, the AAIDD descriptions and interpretations of its own criteria should prevail along with further guidance from the AAIDD User's Guides (Schalock et al., 2007, 2012).

27. In 2007 the committee that developed the AAIDD 10th Edition of the Classification Manual (Luckasson et al., 2002) produced the User's Guide: Mental Retardation Definition, Classification, and Systems of Support-10th Edition (Schalock et al., 2007). The purpose of the User's Guide was to, "... assist ... in understanding the 2002 System fully and applying best practices based on that understanding."

28. In 2012 the User's Guide to the 11th Edition of the AAIDD Intellectual Disability Definition, Classification, and Systems of Support (Schalock et al., 2012) was published. Understanding and application of the AAMR-AAIDD 10th and 11th editions of the Classification Manual require careful consideration of the User's Guide.

29. The Individuals with Disabilities Education Act (IDEA, 2004, 2006), at 34 C.F.R. 300.8 (2), defines intellectual disability as

> "Significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance."

30. In 2010 Congress changed federal terminology from mental retardation to intellectual disability in what was called Rosa's Law (PL 111-256). In 2013 the American Psychiatric Association's DSM 5 discontinued the term mental retardation and adopted the term intellectual disability.

31. The IDEA definition of intellectual disability in paragraph 28 is consistent with the modern definitions of intellectual disability by the AAIDD and APA DSM 5 described above. In my analysis of Mr. Smith' capabilities I will use the AAIDD and DSM 5 definitions and criteria.

MILD INTELLECTUAL DISABILITY

32. The major problems in determining whether a particular case meets the diagnostic criteria for ID involves persons with intellectual and adaptive abilities at the upper end of the ID range – those with Mild Intellectual Disability (Mild ID) – and not those with more severe levels of ID. Persons at the more severe levels of ID generally are easily diagnosed as such due to physical signs of disability and intellectual and adaptive behavior performance far below population averages. As a result, in the National Academy of Sciences Panel report (Reschly et al., 2002) mentioned earlier, the focus was on individuals at the upper end of the ID range (IQ approximately 55 to 75), not those with severe levels of ID (IQ<55), whose ID diagnosis rarely is at issue.

33. Persons with Mild ID typically "pass" as normal in everyday situations, including many employment settings. Co-workers often *cannot* reliably identify persons with Mild ID unless job demands require the use of literacy skills (e. g., reading a shop manual), challenging abstract reasoning, or complex problem solving. Persons with Mild ID typically do best with well-established routines that are not changed frequently and do not require complex thought or problem solving. Many persons with Mild ID are not recognized *formally* as a person with a disability in employment and community settings.

34. Mild ID has been recognized as a distinct diagnostic entity for over 100 years (Reschly, 1992, 2013). From the lay perspective, the adjective "mild" is misleading, perhaps suggesting a non-significant degree of impairment. In fact, persons with Mild ID have substantial and chronic problems with everyday coping due to limited thinking and understanding that result in adaptive behavior deficiencies (Snell & Luckasson, 2009). Mild ID involves significantly limited ability and competencies required for adequate coping with normal everyday environments. Most important, Mild ID limits the ability to reason abstractly and make sound judgments about everyday activities and responsibilities and, thereby, limits the capacity to use reasoning and exercise judgment in considering the likely consequences of behaviors and diminishes the capacity to behave in a socially responsible manner.

35. Mild ID is different qualitatively and quantitatively from both normal development and more severe levels of ID. Mild ID is a subset of ID; any individual with Mild ID meets the diagnostic criteria for ID as well. Although they meet the diagnostic

criteria, individuals with Mild ID are often misdiagnosed, and are therefore often overlooked due to misinformed societal perceptions of what it means to be intellectually disabled.

36. In addition, individuals with Mild ID often have developed a keen ability to mask their significant limitations, making proper recognition and diagnosis all the more challenging. The masking phenomenon is well known in the research on Mild ID and was described extensively in a monograph by Robert Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded*. (Edgerton, 1967, 1993, 2001; Edgerton, Ballinger, & Herr, 1984; Goodman, 1989; Peltopuro, Ahonen, Kaartinen, Seppala, & Narhi, 2014; Snell & Luckasson, 2009). Some persons with Mild ID adopt an interaction style of bragging about their capabilities and exaggerating their importance in an effort to "pass" as normal.

37. Mild ID is different from normal development in the level and quality of intellectual functioning and adaptive behavior performance. Persons with significant limitations in general intellectual functioning have a significantly reduced capacity to learn, recall, and reason (Campione, Brownlow, & Ferrara, 1982; Campione, Brownlow, Ferrara, & Bryant, 1985; Reschly, 1987, 2013; Snell & Luckasson, 2009). Such persons are particularly limited in applying abstract reasoning (e.g., moral or ethical principles) to practical situations and in spontaneously recalling thinking strategies to solve problems. These fundamental intellectual deficits affect everyday activities and responsibilities. Other learning deficits reported frequently with persons with low intellectual ability include difficulty in learning tasks even when taught repeatedly, applying basic

learning to new situations, and severe limitations in literacy skills. As discussed above, adaptive behavior refers to competencies in dealing with the everyday responsibilities of children, youth, and adults in the conceptual, social, and practical domains.

38. Mild ID is different from severe levels of ID qualitatively and quantitatively. Severe levels of ID are more easily identified and, hence, more familiar to the general public. Persons with more severe levels of ID nearly always show,

a. Significant physical signs of ID, that is, they look like they have a disability,

b. Identifiable underlying biological disorders that can be said to "cause" the ID,

c. Comprehensive deficits in all adaptive behavior domains (often including very basic self-help skills),

d. Early identification, usually by age 2, nearly always by health care professionals, and

e. Need for permanent, life-long daily guidance and protection.

39. In contrast to the characteristics of persons at severe levels of ID, persons with Mild ID,

a. Do not show physical stigmata (they look normal) and cannot be identified as likely cases of ID from physical appearance;

b. Do not have identifiable biological disorders that can be regarded as "causes" of the ID, although many have evidence of developmental factors that diminish intellectual and adaptive performance such as premature birth, low birth weight, and exposure to toxic environments (Donovan & Cross, 2002, Chapter 5).

c. Have areas of strength and weaknesses in adaptive behaviors, e.g., adequate self-care (grooming, eating, toileting) and deficits in more complex reasoning and judgment that interfere significantly with personal independence and social responsibility;

d. Are typically identified (if at all) after age 5, following entrance to public school settings, through referrals by teachers due to chronically poor academic and social performance in the classroom;

e. Often are *misclassified* in school special education programs as specific learning disability (SLD) and receive the "LD" label when in fact the consistency and level of their deficits are more consistent with mild ID;

f. Need continuing, usually intermittent, guidance and protection in the community through the adult years in order to avoid exploitation and to cope adequately. The person(s) providing this guidance were identified as "benefactors" in the literature over the last 50 years (Bailer, Charles, & Miller, 1967; Edgerton, 2001; Koegel & Edgerton, 1984; Snell & Luckasson, 2009). A benefactor provides guidance and periodic assistance in avoiding trouble and meeting expectations for social responsibility.

40. These differences between Mild ID and severe ID underscore the range of abilities that persons who have ID can display. It is worth repeating that any individual with Mild ID is also a person with ID; the former designation is a subset of the latter.

41. The use of the diagnosis of Mild ID in public school settings with special education programs varied significantly in the latter half of the 20th century. In the 1950s most public schools had little if anything

that would resemble modem special education. Few children were identified with disabilities and those with severe disabilities often were barred from public school enrollment by local and state policies. In the earlier period, larger cities in certain states had some, but by today's standards, very limited special education services. The most common service pattern was speech therapy provided on an itinerant basis in some schools that addressed almost exclusively articulation and fluency (stuttering) problems and special classes for students with what was then termed educable mental retardation. There were very few programs for students with more subtle disabilities such as specific learning disability and, rarely, emotional disturbance. Many students with what would now be recognized as disabilities either were not identified in school settings or excluded from public school participation. The most frequently diagnosed disability, and in most school districts, the only disability diagnosed in the public schools from 1950 to 1975, was educable mental retardation equivalent to the current term Mild Intellectual Disability. Unless there is specific information contradicting the inference of educable mental retardation, it can be assumed that students in 1950s special education programs were there under the diagnosis of educable mental retardation, or what now is called mild intellectual disability. Since 1975 the diagnosis of what was previously called educable mental retardation declined significantly for a variety of reasons (Reschly, 2013).

42. Mild ID often is associated with poverty and tends to run in families. Perhaps 80% of all persons with Mild ID have family members (parents, siblings, cousins, aunts, uncles) who are significantly impaired intellectually (Reschly, 2013; Richardson, 1981), a finding that is true across race/ethnicity. This form of

Mild ID was attributed to cultural-familial or psychosocial disadvantage origins in prior AAMR-AAIDD Classification Manuals (Grossman, 1973, 1983; Spitz, 2006) to signify the combined influences of the low family potential for intellectual functioning and the deleterious effects of impoverished environments. In order to avoid stereotypes it is essential to point out that the same cultural-familial and psychosocial disadvantage factors apply equally to children and adults of all races/ethnicities in impoverished environments (Richardson, 1981; Spitz, 2006). Although some cases of Mild ID have other origins, the majority of cases are attributable to cultural-familial and psychosocial disadvantage in combination with severe poverty. Connected to the cultural-familial and psychosocial disadvantage etiologies of Mild ID are numerous biological influences associated with poverty, such as higher levels of poor nutrition, maternal alcohol and drug abuse during pregnancy, poor prenatal health care, greater exposure to environmental toxins such as lead, premature birth, and low birth weight for gestational age (Donovan & Cross, 2002, Chapter 3). Moreover, the incidence of physical and sexual abuse is significantly higher in poverty circumstances as well as social and physical neglect. Although the vast majority of persons in extreme poverty are NOT persons with Mild ID, the risk of this condition is far higher in specific families in very low socioeconomic environments.

43. Persons with Mild ID as adults often can succeed in competitive employment, but nearly always in unskilled occupations that do not require advanced training/education, abstract thinking, and complex decision-making. Older research suggested that about 50% of persons with Mild ID could achieve competitive employment and economic self-support, frequently

aided by someone who assists the individual with the more complex interactions with society, i.e., a benefactor. Benefactors often provide periodic assistance with obtaining a job, completing complex paperwork such as that associated with applying for a job, income tax and Social Security forms, meeting community responsibilities, and handling money. Absent benefactor and periodic supports of other kinds, most persons with Mild ID struggle and often fail with maintaining employment, handling money, in avoiding exploitation, and conforming to social expectations and legal requirements (Snell & Luckasson, 2009). Benefactors typically are more competent family members (parents or siblings) or spouses, employers, or neighbors.

44. There in no bright line separating Mild Intellectual Disability from Borderline Intellectual Functioning (AAIDD, Schalock, et al., 2010; APA DSM 5, 2013; and Peltopuro et al., 2014). Persons with scores in the IQ range Of 75 to 85 often function on a daily basis similarly to or, sometimes, lower than persons in the traditional Mild ID range of 55 to 75. Persons with Borderline Intellectual Functioning (BIF) have difficulties with thinking through the consequences of their actions, understanding moral principles, considering alternative courses of action, and controlling impulses. The overlap among BIF and Mild ID in thinking or cognitive deficits is especially prominent in the lower range of BIF at the marginal range where there is no clear natural cut point separating the two conditions.

Diagnosis of Joseph C. Smith: Sources of Information

45. Multiple sources of information about Mr. Smith were considered in reaching a conclusion about his

status as a person with Mild Intellectual Disability (Mild ID). These sources were,

a. Educational records including evaluations for special education eligibility and placemen in special education in the disability categories of "emotionally conflicted" in early grades and "educable mentally retarded" in later school grades.

b. Educational records that contained academic achievement measures and class grades along with placement initially in part-time special education, later changed to full-time special education.

c. Dr. James F. Chudy psychological evaluation in 1998 that included measures of intellectual functioning, academic achievement, emotional status, and personality functioning.

d. Dr. James F. Chudy testimony in 1998.

e. Dr. John Matthew Fabian Intellectual Disability Evaluation, February 24, 2017.

f. Dr. Glen D. King Forensic Psychological Report, February 22, 2107.

BACKGROUND INFORMATION AND SOCIAL HISTORY

46. Dr. Fabian provided a review of Mr. Smith's developmental history and family background in his February 2017 evaluation. Mr. Smith experienced significant amounts of verbal and physical abuse as well as early exposure to alcohol. His living situation was unstable as he appeared to be shuttled between parents who had divorced when he was about nine. Dr. Fabian in particular reported many details regarding Mr. Smith's home background and developmental course. The significance of this information is that these conditions are often associated with poverty and

the development of lower intellectual functioning. From a developmental risk perspective, Mr. Smith experienced many threats to normal development with few protective conditions that would overcome the risk conditions (Masten, 2001, 2014). Multiple risk factors including low ability are known to increase the likelihood of negative adult outcomes.

Intellectual Assessment Standards and Criteria

47. The 2010 American Association on Intellectual and Developmental Disabilities (AAIDD) Classification Manual defined significant limitations in intellectual functioning for a diagnosis of intellectual disability as,

> "An IQ score that is *approximately* two standard deviations below the mean, considering the standard error of measurement for the specific instruments used and the instrument's strengths and weaknesses. Practically, this results in an intellectual functioning criterion as a score range from approximately IQ 65 to IQ 75, assuming a standard error of measurement of 5." (Schalock et al., 2010 p. 31).

48. The standard error of measurement on the best recently standardized tests of intellectual functioning have internal consistency reliabilities of about 0.95 and stability reliabilities of about 0.91. Use of the classic formula these reliabilities produce a standard error of measurement of about 5 (depending on the reliability estimate used and whether a 90% or 95% confidence interval is established).

49. The AAIDD Classification Manual views the IQ requirement as flexible around an IQ score of approximately 70. In other words, according to the AAIDD, assuming intellectual functioning tests with a

mean of 100 and standard deviation of 15, IQ scores above 70, up to 75 (given a standard error of measurement [SEM] of 5 points), can be considered indicative of significant limitations in intellectual functioning and meet the first prong of the ID diagnosis.

50. The AAIDD was explicit in instructing clinicians and others to see the general intellectual functioning criterion as a range of scores, not as a simple precise, immutable score. Specifically, the *User's Guide* states,

> "An IQ of 70 is most accurately understood not as a precise score, but as a range of confidence with parameters of at least 1 standard error of measurement (i.e., scores of about 66-74; 66% probability) or parameters of two standard errors of measurement." (i. e., scores of 62-78; 95% probability)." (Schalock et al., 2007, p. 12).

51. In APA-DSM V (2013) the intellectual criterion is described as,

> "Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +/- 5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 +/- 5)."

52. Understanding and application of what has been called the Flynn Effect (1984, 1998, 2012), named after the New Zealand scholar who first described the phenomenon of intellectual functioning norms becoming less stringent over time, is recommended in the AAIDD *User's Guides* (Schalock et al., 2007, 2012) and mentioned in DSM 5. First, the Flynn Effect

means that the normative standards (norms) for measures of intelligence become less stringent over time at the rate of approximately 0.3 points per year. For example, if the norms for an intelligence test are 10 years old, the population mean on the test no longer is 100, but 103 [100 + (0.3)(10)]. Moreover, the point that is two standard deviations below the mean no longer is 70, but 73 (assuming a mean of 100 and standard deviation of 15). A simple correction for normative standards obsolescence is to multiple the number of years since the test was standardized by 0.3, then subtracting the resulting number from the obtain IQ scale scores (Full-Scale and part scales such as Verbal Comprehension and Perceptual Reasoning).

53. The AAIDD *User's Guide* (2007) was explicit about the consideration of the Flynn Effect, "In cases where a test with aging norms is used, a correction for the age of the norms is warranted." (p. 20). The *User's Guide* then applies the Flynn correction of 0.3 points per year to a set of test scores. The *User's Guide* concluded, "Thus the clinician needs to use the most current version of an individually administered test of intelligence and take into consideration the Flynn Effect as well as the standard error of measurement when estimating an individual's true IQ score." (p. 21). A virtually identical statement about corrections for obsolete norms appears in the 2012 *Users Guide* (Schalock, 2012, p. 23).

54. The Technical Manual for the Wechsler Adult Intelligence Scale 3rd Edition (WAIS-III) (Wechsler, 1997) contained this treatment of the Flynn Effect.

> "Updating of Norms. Because there is a real phenomenon of IQ-score inflation over time, norms for a test of intellectual functioning should be updated regularly (Flynn, 1984,

> 1988, 2012; Matarazzo, 1972). Data suggest that an examinee's IQ score will generally be higher when outdated rather than current norms are used. The inflation rate of IQ scores is about 0.3 points each year. Therefore, if the mean IQ of the U.S. population on the WAIS-R was 100 in 1981, the inflation might cause it to be about 105 in 1997." (pp. 8-9).

55. The Flynn Effect is a scientific fact! Two recent comprehensive meta-analyses based on hundreds of empirical articles were published in high quality journals with identical results (Pietschnig & Voracek, 2015; Trahan, Stuebing, Fletcher, & Hiscock, 2014). The research foundation for the Flynn Effect is unequivocal and establishes strong support to correct IQ scores for the obsolescence of norms using the 0.3 points per year algorithm.

56. Increasingly test authors and experts in intellectual assessment are recognizing the reality of the Flynn Effect (e. g., Gresham & Reschly, 2011; Kaufman, 2010a, b; Reynolds, Niland, Wright, & Rosenn, 2010; Weiss, 2010) including recommendations to adjust scores related to high stakes decisions about individuals (Kaufman, 2010b). Authors of recently published tests increasingly endorse the application of the Flynn Effect (e. g., Kaufman, 2010 a, b; Reynolds et al., 2010).

57. The most recent Wechsler Adult Intelligence Scale IV (WAIS; Wechsler, 2008) Technical Manual recognizes the reality of the obsolescence of normative standards with the passage of years as follows,

> "Research also suggests that older norms produce inflated scores on intelligence measures (Flynn, 1984, 1987, 1999, 2007;

> Flynn & Weiss, 2007; Matarazzo, 1972). Test scores should be based on normative information that is both contemporary and representative of the relevant population. (Wechsler 2008, WAIS-IV Technical Manual, p. 22).

58. Later in the WAIS 2008 Technical Manual direct comparison of the WAIS IV and WAIS III scores for persons with low ability were reported (See WAIS-IV Technical Manual, p. 78, Table 5.7). The predicted Flynn Effect was 3.3 points, WAIS III higher than WAIS IV, based on 11 years between the publication of the WAIS IV (2008) and the publication of the WAIS III (1997). The actual difference for the Full-Scale IQ score was 4.1 points, slightly higher than predicted from the Flynn research (citations in prior paragraph). Based on the evidence in the WAIS IV Technical Manual and other research, correction of the obsolescence of norms using the 0.3 per year is fully justified.

59. The Flynn Effect is especially pertinent to intellectual evaluations conducted with Mr. Smith as a child and adult because in several instances intellectual tests were used that had out of date normative standards. A correction of the IQ scores of 0.3 points per year of obsolescence should be applied to the results reported for Mr. Smith. In one instance, the normative standards were 20 years out of date (see discussion below).

60. Practice effects must be considered when a higher score is reported on the same or highly similar test administered to the same individual at a subsequent time. Scores usually increase if the same or highly similar instrument is administered to the same individual. A recent review of practice effects indicates that they are larger than typically

understood and can persist over many years (Calamia, Markon, & Tranel, 2012). Best practice is to administer a different highly regarded and sound instrument or to accept the original score unless there are compelling reasons not to do so.

61. Intellectual assessment must be conducted by appropriately educated and credentialed professionals, in accordance with the standardization procedures established when the test was normed with a representative sample of persons in the US across the ages included on the test. Intellectual assessments used to determine significant limitations in intellectual functioning as part of the ID diagnosis should be individually administered measures that require performance across broad factors of intelligence and yield a full-scale or composite score. Tests administered to *groups* of examinees are not acceptable nor are *short* forms of more thorough assessment instruments or tests with a single type of item (Reschly et al., 2002; Schalock et al., 2010).

62. Performance across intellectual and achievement tests varies *within* most normal individuals and individuals with Mild ID. The expectation of flat profiles, that is, little variation across subtests and domains, is *not* supported by evidence (Bergeron & Floyd, 2013). Therefore, interpretation of the performance of persons who may be ID *cannot* cite occasional strengths as inconsistent with the ID diagnosis (Schalock et al., 2010). According to the AAIDD 11th ed. classification manual (Schalock, 2010, p. 34) "it is the position of the AAIDD that intellectual functioning (as defined at the beginning of this chapter) is best conceptualized and captured by the general factor of intelligence (g)." The Full-Scale IQ or composite score on modern measures of intelligence

are good measures of the general factor of intelligence (Floyd, Reynolds, Farmer, & Kranzler, 2013).

63. Diagnosis of any disability or abnormal condition cannot be made from studying the patterns of scores on tests like the Wechsler Adult Intelligence Test (4th ed) (WAIS-IV; Wechsler, 2008). Specifically, a condition like specific learning disability cannot be diagnosed from the WAIS-IV scale differences or subtest patterns, a fact well known in special education (Reschly & Hosp, 2004). Based on our results, states have abandoned the 1970s erroneous practice that Wechsler scale or subtest differences can be used to diagnose or confirm the existence of learning disability. Experts in the interpretation of the WAIS-IV clearly acknowledge that scale or subtest differences cannot be used to diagnose specific learning disability or any other disability or condition. This principle is clearly stated by Lichtenberger & Kaufman (2013) at p. 226 and 227, concluding *"...the idea that a VCI-PRI difference of 10 points or even 20 points denotes pathology is unwarranted and unsupported from the standardization data."* (p. 227). Citing the higher PRI than VCI is not a sound or research supported method to diagnose or confirm the existence of a learning disability and has been refuted with data.

64. Multiple individually administered measures of general intellectual functioning have been administered to Mr. Smith during his childhood, adolescence, and adult years. The results of these tests are summarized in the table below with appropriate adjustments for the obsolescence of the normative standards when the test was given. As noted previously the AAIDD, 2010 and the DSM 5 emphasize the use of the Full Scale IQ in high stakes decisions. Lichtenberger and Kaufman (2013) specify that the

Full-Scale IQ be used in classification decisions like intellectual disability and giftedness, that is, *"Always interpret a person's overall score on the WAIS-IV whenever a global score is essential for diagnosis (e. g., intellectual disability."* (p. 162). Both authoritative organizations also recognize the problems with the obsolescence of the normative standards and the AAIDD explicitly recommends adjusting scores for the Flynn Effect. I followed these recommendations from AAIDD and DSM 5 in preparing the summary of the measures of general intellectual functioning that appears in Table 2.

65. Table 1. Summary of Intellectual Assessment with of Joseph C. Smith

Test/Year Given/Age	Norms Date	Full-Scale	**Flynn Full Scale**	VIQ/ VCI	Flynn VIQ/ VCI	VIQ/ VCI VCI	Flynn PIQ/ PRI	Ability Level/ Diagnosis Special Educ.
WISC-R 1979 Age 8	1972 .3 x 7= 2.1	75	**73**	80	78	73	71	Borderline Emotionally Conflicted-RC
WISC-R 1982 Age 12	1972 .3 x 10 =3.0	74	**71**	80	77	72	69	Borderline None 1982 EMR 1984 Special Class or Resource
WAIS-R 1998 Age 28	1979 .3 x 19 =5.7	72	**67**	73	68	72	67	Borderline Learning Disorder
WAIS-IV 2017 Age 46	2007 .3 x 10 =3.0	74	**71**	72	69	86	83	Borderline Learning Disorder
S-B 5 2017 Age 46	2001 .3 x 16 =4.8	78	**73**	83	78	75	70	Borderline/ID Intellectual Disability

66. All the Full-Scale scores on measures of general intellectual functioning were in the critical range of IQ 65 to 75. Mr. Smith meets the AAIDD, 2010 and DSM 5 first criterion for a diagnosis of Mild Intellectual Disability, that is, significant limitations in general intellectual functioning.

67.

Significant Deficits in Adaptive Behavior

68. The 9th Edition of the AAIDD Classification Manual in 1992 defined adaptive behavior as a set of 10 skills areas, communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety (Luckasson et al., 1992). The American Psychiatric Association DSM IV (2000) and DSM IV-TR (2004) adopted this scheme with only one difference. The APA placed a comma between Health and Safety, creating 11 areas. More recent editions of the AAIDD Classification Manual changed the scheme form 10 adaptive skills areas to three broad adaptive behavior domains, Conceptual, Social, Practical. The most recent APA DSM (DSM 5, 2013) again followed the AAIDD and adopted the same three adaptive behavior domains. A table published by AAIDD explaining the relationship between the adaptive skills areas and the broader adaptive behavior domains is reprinted below from Luckasson et al., 2002, p. 82.

Table 2. Table Illustrating the Organization of Adaptive Behavior Skills and Domains (Luckasson et al., 2002, p. 82)

Adaptive Behavior Domains (Skill Areas) in the AAIDD 10th and 11th ed. 2002 and 2010	Representative Adaptive Behavior Skills in 10th ed (2002)	Skills Areas Listed in the 9th ed (1992)
CONCEPTUAL	Language Reading and Writing Money Concepts Self-Direction	Communication Functional Academics Self-Direction Health and Safety
SOCIAL	Interpersonal Responsibility Self-Esteem Gullibility Naiveté Follows Rules Obeys Laws Avoids Victimization	Social Skills Leisure
PRACTICAL	Activities of Daily Living Instrumental Activities of Daily Living Occupation Skills Maintains Safe Environments	Self-Care Home Living Community Use Health and Safety Work

69. The 2002 and 2010 AAIDD Classification Manuals described the adaptive behavior prong as, "significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills." (Luckasson et al., 2002, p. 1; Schalock et al., 2010, p. 1). The definitions of each domain appear in Schalock et al., (2010, p. 44) as,

> Conceptual: language; reading and writing; and money, time, and number concepts.
> Social: interpersonal skills, social responsibility, self-esteem, gullibility, naiveté (i.e., wariness), follows rules/obeys laws, avoids being victimized, and social problem solving.
> Practical: activities of daily living (personal care), occupational skills, use of money, safety, health care, travel/transportation, schedules/routines, and use of the telephone.

Assessment of Adaptive Behavior

70. It is critical to understand — as the AAIDD explicitly warns — "Within an individual, limitations often coexist with strengths." (Luckasson et al., 2002; Schalock et al., 2010, at p.1). Therefore, it should *not* be expected that persons with Mild ID would be deficient in *all* aspects of adaptive behavior. The AAIDD and DSM 5 specify that a significant deficit/limitation in *one* of the three domains of adaptive behavior, conceptual, social, or practical, is sufficient for the diagnosis of intellectual disability, assuming significant deficits/limitations in general intellectual functioning. APA-DSM 5 adopted the same criterion; that is, a deficit in one of three adaptive behavior domains is sufficient to meet the adaptive behavior prong of the intellectual disability diagnosis. The AAIDD's precise explanations of the three adaptive functioning domains reflect state of the art

understandings in the relevant scientific and practice communities.

71. Thus, the AAIDD requires *only one* adaptive behavior domain to be two standard deviations below the mean to meet the criteria for a significant limitation in adaptive behavior. Significant limitations in all three domains are *not* required.

72. The DSM 5 followed the AAIDD **11**th Edition of the *Classification Manual* (Schalock et al., 2010) in defining three domains of adaptive behavior, conceptual, social, and practical. The DSM 5 definition was, "Deficits in adaptive functioning refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background. Adaptive functioning involves adaptive *reasoning* in three domains: conceptual, social, and practical. " (p. 37). The descriptions of competencies within the adaptive behavior domains were parallel to the AAIDD descriptions. The APA-DSM 5, like AAIDD 2010, specifies that significant deficits/limitations in one of the three domains is sufficient to meet the adaptive functioning criterion. APA-DSM 5 does not, however, suggest a numerical cut score or range for defining a significant limitation in adaptive behavior.

73. Consensus exists supporting the assessment of adaptive behavior using information from a variety of sources (the individual, significant others knowledgeable about the individual) and multiple methods of data gathering (e. g., review records, observations, interviews, testing) (AAIDD User's Guide, Schalock et al., 2012, p. 18).[2] Decisions on adaptive behavior status must then

[2] This is especially important in a prison setting, where some standard methods such as interviewing work supervisors and

be based on the convergent validity principle involving systematic consideration of the consistency or inconsistency of information from multiple sources and multiple methods of gathering information. Good consistency across methods and sources justifies a firm decision about adaptive behavior.

74. Adaptive behavior inventories nearly always use third party informants to report the capabilities of the individual. Unlike measures of general intellectual functioning, that are administered directly to the individual and seek the individual's best performance, adaptive behavior inventories are derived from the observations and reports of one or more persons who know the individual and can answer questions on their *typical* behaviors across a wide range of behavioral challenges in different settings. Of course, given that persons with Mild ID and their families seek to pass as normal (Edgerton, 1967, 1984, 1993; Goodman, 1989), in order to mask the individual's deficiencies and/or to deny their significance, locating reliable reporters of performance can be challenging.

75. In the case of an incarcerated individual, administration of an adaptive behavior inventory is nearly impossible because the behavior observed is severely limited to one setting and coping challenges are minimal. For example, prisoners do not prepare their own meals, clean their own clothes, or decide how to allocate time to work and family responsibilities. For these reasons, the adaptive behavior status of incarcerated individuals has to be inferred from a wide range of information gathered primarily from reports of behaviors prior to incarceration.

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significant others in home and community settings are often impossible and likely unreliable.

76. Unfortunately, methods to assess adaptive behavior by standardized measures generally accepted in the field of psychological testing are not as well established with adults, and are often not feasible in a maximum-security prison setting. (Reschly, 2013; Reschly et al., 2002). The authors (Sara Sparrow and Thomas Oakland) of the two most widely used standardized measures of adaptive behavior explicitly rejected the use of prison guards and other prison officials as appropriate respondents for adaptive behavior measures *because* of the severe limitations imposed by the prison environment on the expression of independence, choice, judgment, and social responsibility. It is important to note that the authors of both of the widely used adaptive behavior measures endorse the use of retrospective accounts of adaptive behavior when circumstances prevent gathering contemporary information (Harrison & Oakland, 2015; Sparrow et al., 2005).

77. Authoritative ID sources recommend administration if at all possible of one or more adaptive behavior inventories to knowledgeable informants as part of the overall assessment of adaptive behavior in diagnoses of ID (APA-DSM 5, 2013; AAIDD-11; Schalock, et al., 2010). The evaluation of Mr. Smith follows the APA DSM 5 and AAIDD 11th Ed Classification Manual procedures, processes, and criteria.

78. Before presenting the analysis of Mr. Smith' adaptive behavior, it is important to recognize the fact that persons with ID typically show both strengths and limitations in adaptive behavior (See Schalock et al., 2010, p. 1). No *single* weakness or strength is sufficient to establish or disconfirm significant limitations in adaptive behavior. In the analyses by Drs. King and Fabian, Mr. Smith displayed the typical

adaptive behavior strengths typical with persons with Mild Intellectual Disability as well as significant adaptive behavior limitations. (See Dr. King and Dr. Fabian reports).

79. The AAIDD Classification Manual (2010, at pp. 51-52) expressed strong cautions in using self-reports of adaptive behavior competencies by persons with low ability. The following direct quotations capture the essence of these cautions.

a. persons performing in the range of borderline to mild intellectual disability are, "more likely to mask their deficits and attempt to look more able and typical than they actually are." (p. 52)

b. "persons with ID typically have a strong acquiescence bias or a bias to please that might lead to erroneous patterns of responding."

c. The AAIDD recommendation regarding diagnosis and classification diminishes the value of self-report, "Recognize that self-ratings have a high risk of error because people with ID are more likely to attempt to look more competent and "normal" than the actually are, as well as frequently exhibit an acquiescence bias." (p. 102 in AAIDD Classification Manual 2010).

80. The adaptive behavior results reported by Dr. King used a self-report procedure that is available for the Adaptive Behavior Assessment System (3rd ed.) (ABAS 3; Harrison & Oakland, 2015). The ABAS 3 results reported by Dr. King should be viewed cautiously based on the AAIDD discussion of problems with self-report by persons with low ability.

Analysis of Adaptive Behavior by Domain: Conceptual Skills

81. Dr. Fabian provided an extensive analysis of Mr. Smith's adaptive behavior competencies in his 2017 report. I defer to those results. I will interpret the educational records, particularly the special education records.

82. Educational Performance: School Records. Mr. Smith attended several schools, sometimes changing schools within a specific year and grade. The relatively frequent changes in schools may have undermined his acquisition of academic skills and delayed accurate analysis of his disability status and academic needs. Mr. Smith's participation in special education was initially in the category of "Emotionally Conflicted Disability" that later was changed to "Educable Mental Retardation" (EMR). EMR is an obsolete term for what now is called Mild Intellectual Disability.

83. The assignment of disability labels to children who need special education services in order to make educational progress is somewhat unreliable (Reschly, 2013, 2014; Reschly et al., 2002). Different categories are used, sometimes changing during the course of a student's school career. My experience is that the later categories are more accurate than those assigned in earlier grades because of two factors, (a) Less severe labels are assigned to younger children when ambiguous symptoms often exist that are not definitively associated with only one category to avoid projecting a more negative probable course of development, and (b) Greater experience and performance data are available by later grades to form the basis for a more accurate assignment of a disability category.

84. Little direct information exists regarding Mr. Smith's educational performance in the early school grades. The first document in his school records is a referral for consideration of disability classification and special education participation dated September 22, 1978 when he was in third grade. The referral reflected concerns in two areas, low level of academic skills and behavior problems. Mr. Smith's results on the California Achievement Test were well below third grade level, ([3]Grade Equivalent scores of 1.3 in reading, 2.1 in mathematics, and 0.1 in language). His mother signed a parental consent form agreeing to the evaluation on January 30, 1979. No explanation was given for the delay from September to January. The evaluation conducted by a school psychometrist was completed in early February 1979 with these results

a. WISC-R IQ scores presented in Table 1.

b. Achievement scores from the Wide Range Achievement Test of Reading GE=1st grade 7th month, Spelling 1st grade 8th month, and arithmetic 3rd grade 0 month.

c. "Further evaluation is suggested in order to determine if LD class placement is appropriate."

85. Additional requests for parental consent to evaluate in the additional areas of "Educational Evaluation-measures of academic achievement and Behavior Rating Scales and/or Social Maturity Scale" were presented to and signed by Mrs. Smith on April

[3] A Grade Equivalent is a method to express level of achievement in terms of the average performance of children at a specific time in the school year. For example, Mr. Smith's Grade Equivalent score of 1St grade 3rd month means that he was reading at the average level of children in the third month of first grade.

27, 1979 and September 20, 1979. Again there was no explanation for the delay between the first, second, and third requests for parental consent to conduct these evaluations. The late 1970s were in the early years of state and federal mandates to provide special education services to students with disabilities and many improvements in special education services have been implemented over the last 35 years (Education of the Handicapped, 1975, 1977).

86. An anecdotal behavior observation for 70 minutes was reported on what appears to be September 20, 1979. Mr. Smith was observed in 4th grade while doing "Individual Work at Desk" and "Free Time." The observer reported that during individual work Mr. Smith would not stay on task and would leave his seat to talk to two boys. The observer also commented, "Stared at me, kept pointing at me and laughing w/ 2 boys." During free time he was described in this observation as, "Interacts well w/ peers, Had to be called down by teacher talking too loud high pitched (unreadable word) and Listens to teacher when she reprimands him individually." Results for the Walker Problem Behavior Identification Checklist completed by his teacher were interpreted as "Highly significant score in Acting-out area." The overall results were interpreted, "...suggests definite emotional handicaps." (emphasis in the original).

87. A Placement Committee Report dated October 17, 1979, described him as a slow learner and recommended placement in an "EC Resource Class." On the Total Service Plan document his disability is listed as "Emotional Conflict" with annual goals primarily dealing with behavioral issues and assignment to the EC Resource program for what may be 10 or 20 hours per week. The meaning of the two

listings of 10 hours on the Total Service Plan is ambiguous as to whether the assignment was 10 or 20 hours per week. He apparently continued in a combination of general and special education for the remainder of the 4th grade in the 19791980 school year. A Key-Math Diagnostic Record appeared next in the records listing his Grade Equivalent as 4th grade 2nd month. This result is inconsistent with other achievement information that appeared previously and later in the school records.

88. The May 6, 1981 Individualized Education Program (IEP) that specified the special education services for the 1981-1982 school year listed Peabody Individual Achievement Test results. At the end of 5th grade the average achievement score for students is 5th grade 10th month. Mr. Smith was near grade level in mathematics, but about 3 years behind in the other four achievement areas and in the overall composition score. The Walker Behavior Scale was again interpreted as indicating "acting out and distractibility as areas of weakness."

Peabody Individual Achievement Test	Grade Equivalent	Gap: Current Grade and Achievement Level
Reading Recognition	2nd grade 8th month	3 years 2 months
Reading Comprehension	3rd grade 1st month	2 years 9 months
Spelling	2nd grade 9th month	3 years 1 month
Mathematics	5th grade 7th month	At grade level
General Information	2nd grade 7th month	3 years 3 months
Total Test Composite	3rd grade 1st month	2 years 9 months

89. The May 1981 special education IEP did not list the amount of time in special education or the special education placement (e.g., part-time resource or special class) that typically are included in the IEP. No further information on Mr. Smith's performance in 6th grade during the 1981-1982 school year was available in the records. Apparently, he was retained in the 6th grade based on records for the 1982-1983 year.

90. Mr. Smith was referred in the Baldwin County Schools in November 1982 for an evaluation of his special education status and needs. The referral form lists his current grade as 6th and indicates that he was retained the previous year (1981-1982). The reason for referral was "Emotional Factors."

91. Re-evaluation of his special education status in the Baldwin County Schools yielded Wechsler Intelligence Scale for Children-Revised (WISC-R; Wechsler, 1974) results of Full-Scale IQ=74; Verbal IQ=80; and Performance IQ=72. The WISC-R normative standards were 10 years out of date when the test was administered to him in 1982. The appropriate correction for the obsolescence of the WISC-R normative standards is to subtract 3 points from each score yielding scores or Full- Scale IQ=71; Verbal IQ=77; and Performance IQ=69. At the time of the re-evaluation his special education program was, "currently enrolled in the EC program," but the number of hours per week was not indicated. On the Peabody Individual Achievement Test his overall achievement was at the *age* equivalent of 8 years 3 months, about 4 years 2 months below his current chronological age of 12 years 5 months. The IEP that should have been created subsequent to this evaluation was not in the education records.

92. Mr. Smith apparently transferred from the Baldwin County to the Monroe County Schools in December 1982. The Monroe County Schools Eligibility Report dated March 3, 1983 placed him in a regular class with no special education services and no indication of an educational disability.

93. Mr. Smith enrolled in Monroeville Middle School participated in then Alabama State Testing Program involving the California Achievement Tests in April 1982, obtaining very low percentile ranks over several subjects that varied from 0 to 5th. A percentile rank refers to the proportion of the general population of students at that grade that obtained lower scores. The highest percentile of 5 in mathematics addition means that Mr. Smith scored above 5%, and below 95 % of the

students his age. All other percentiles were below 5, most at 1 or 2, indicating extremely low achievement. Moreover, his scores were a bit higher because he was compared to other students at his grade level, but he had been in school an additional year and was at an older chronological age than his grade level peers.

94. On October 26, 1983 the Monroeville Junior High School Principal wrote to Mr. Smith's mother indicating that he had been suspended from school for five days due to "continuous misbehavior and complete disrespect for the principal ..."

95. A "Student Withdrawal Form" dated March 5, 1984 from the Monroeville Junior High appeared in the education records with grades listed for the five six week periods and the first semester average. He was enrolled for 121 days and present for 112 days, missing five days due to the suspension in October 1983. His grades for the semester in academic subjects were three failures and one D-. Clearly, Mr. Smith was not able to make satisfactory progress in the general education 7th grade curriculum.

96. Mr. Smith was placed again in special education according to a Monroe County Eligibility Report dated March 9, 1984. The exceptionality area was "Educable Mentally Retarded," a special education category requiring low general intellectual functioning and significant deficits in adaptive behavior. The Educable Mentally Retarded classification at the school age level in the 1970s and 1980s is essentially the same as Mild Intellectual Disability before age 18 in the current diagnostic system. The educational placement was "Regular Class with Resource Room Services." The Individual Education Program dated May 18, 1984 established goals and objectives in reading, math, and language arts skills. It is significant to note that this

IEP placed primary emphasis on academic deficits rather than behavior problems.

97. Mr. Smith's special education placement in 8th grade was "Spec. Ed. EMR self-contained" according to a Monroe County summary form in April 1985. The form included the recommendation to continue this placement. The Stanford Achievement Test scores were very low (< $2n^d$) with the exception of the math percentile rank of 10. Even the higher score in math means that 90% of students in the 8th grade had higher scores. Moreover, Mr. Smith was compared to students who were about one year younger in terms of chronological age.

98. Mr. Smith dropped out of formal education during the 1985-1986 school year. He has not earned the General Education Diploma and continues to show significant deficits in literacy skills (see Dr. Fabian Report).

99. Summary Education Records. Mr. Smith was a child with a disability that was recognized relatively early in his school career involving both behavior and learning problems. By the middle school grades his poor learning progress along with low intelligence scores resulted in the assignment of the education disability category, Educable Mentally Retarded, essentially equivalent to the current category of Mild Intellectual Disability. The greater experience with Mr. Smith and more thorough observations of his behavior and learning resulted in the Educable Mentally Retarded classification.

100. The educators paid more attention to Mr. Smith's emotional-behavior problems in the early grades although evidence for significant learning deficits clearly existed at that time. The phenomenon

of closer attention to behavior-emotional behavior problems than very slow progress in learning and other deficits associated with intellectual disability is a long standing process called "diagnostic overshadowing" (Reiss & Szyszko, 1983), meaning that the emotional-behavior symptoms receive the most attention, often leading to failure to recognize Mild Intellectual Disability. It is important to note that mental disorders of children and adults can co-exist with intellectual disability a fact clearly recognized by the American Psychiatric Association and the American Association on Intellectual and Developmental Disabilities.

a. "Co-occurring mental, neurodevelopmental, medical, and physical conditions are frequent in intellectual disability, with rates of some conditions (e. g. mental disorders, cerebral palsy, and epilepsy) three to four times higher than the general population." (APA DSM 5 p. 40).

b. "The most common co-occurring mental and neurodevelopmental disorders are attention-deficit/hyperactivity disorder; depressive and bipolar disorders; anxiety disorders; autism spectrum disorder; stereotypic movement disorder (with or without self-injurious behavior); impulse-control disorders; and major neurocognitive disorders. Major depressive disorder may occur throughout the range of severity of intellectual disability." (APA DSM 5 p. 40).

101. The diagnosis of Educable Mentally Retarded was well established in Mr. Smith's education records. That diagnosis during the school age years has the same meaning and nearly identical classification criteria as the modern diagnosis of Mild Intellectual Disability.

Date April 3, 2017

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References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th Edition-Text Revision).* Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)* Washington, DC: Author.

Atkins v Virginia, 536 U.S. 304 (2002)

Bailer, W., Charles, D., & Miller, E. (1967). Mid-life attainment of the mentally retarded. *Genetic Psychology Monographs, 75,* 235-329.

Bergeron, R., & Floyd, R. G. (2013). Individual part score profiles of children with intellectual disability: A descriptive analysis across three intelligence tests. *School Psychology Review, 42,* 22-38.

Campione, J. C., Brownlow, A. L., & Ferrara, R. A. (1982). Mental retardation and intelligence. In R. J. Sternberg (Ed.), *Handbook of Human Intelligence* (pp. 392- 490). Cambridge, England: Cambridge University Press.

Campione, J. C., Brownlow, A. L., Ferrara, R. A., & Bryant, N. R. (1985). Breakdowns in flexible use of information: Intelligence-related differences in transfer following equivalent learning performances. *Intelligence, 9,* 297-315.

Calamia, M. Markon, K., & Tranel, D. (2012). Second time around: Meta-analyses of practice effects in neuropsychological assessment. *Clinical Neuropsychologist, 26(4),* 543-570.

Charles, D. C. (1953). Ability and accomplishment of persons earlier judged mentally deficient. *Genetic Psychology Monographs, 47,* 3-71.

Doll, E. A. (1941). The essentials of an inclusive concept of mental deficiency. American *Journal of Mental Deficiency, 46,* 214-219.

Donovan, M. S., & Cross, C. T. (2002). *Minority students in special and gifted education.* Washington, DC: National Academy Press.

Duvall, J. C., & Morris, R. J. (2006). Assessing mental retardation in death penalty cases: Critical issues for psychology and psychological practice. *Professional Psychology: Research and Practice, 3*7, 658-665.

Edgerton, R. B. (1967). The *cloak of competence: Stigma in the lives of the mentally retarded.* Berkeley, CA: University of California Press.

Edgerton, R. B. (Ed.). (1984). Lives *in process: Mentally retarded adults in a large city.* Washington, DC: American Association on Mental Deficiency.

Edgerton, R. B. (1993). The *cloak of competence: Stigma in the lives of the mentally retarded* (Revised and Updated). Berkeley, CA: University of California Press.

Edgerton, R. B. (2001). The hidden majority of individuals with mental retardation and developmental disabilities. In A. M. Tymchuk, K. C. Larkin, & R. Luckasson (Eds.), *The forgotten generation: The status and challenges of adults with*

mild cognitive limitations (pp. 3-19). Baltimore: Paul H. Brookes.

Edgerton, R. B., Ballinger, M., & Herr, B. (1984). The cloak of competence: After two decades. *American Journal of Mental Deficiency, 88,* 345-351.

Education of the Handicapped Act. (1975, 1977). PL 94-142, 20 U.S.C. 1400-1485, 34 CFR-300.

Floyd, R. G., Reynolds, M. R., Farmer, R. L., & Kranzler, J. H. (2013). Are the general factors from different child and adolescent intelligence tests the same? Results from a five-sample, six-test analysis. School Psychology Review, 42, 383-401

Flynn, J. R. (1984). The mean IQ of Americans: Massive gains 1932 to 1978. *Psychological Bulletin, 95, 29-51.*

Flynn, J. R. (1998). IQ gains over time: Toward finding the causes. In U. Neisser (Ed.), *The rising curve: Long-term gains in IQ and related measures* (pp. 25-66). Washington DC: American Psychological Association.

Flynn, J. R. (2012). *Are we getting smarter? Rising IQ in the twenty-first century.* Cambridge, England: Cambridge University Press.

Goodman, J. F. (1989). Does retardation mean dumb? Children's perceptions of the nature, cause, and course of mental retardation. *Journal of Special Education, 23,* 313-329.

Gresham, F. M., & Reschly, D. J. (2011). Standard of practice and Flynn Effect testimony in death penalty cases. *Intellectual and Developmental Disabilities, 49(3),* 131-140.

Grossman, H. (Ed.). (1973). *Manual on terminology and classification in mental retardation.* Washington, DE: American Association on Mental Deficiency. Also 1977 revision.

Grossman, H. J. (Ed.) (1983). *Classification in mental retardation.* Washington D.C.: American Association on Mental Deficiency.

Hall v Florida, 134 US Supreme Court, 1986 (2014).

Individuals with Disabilities Education Improvement Act (1991, 2004, 2006) 20 U. S. C. 1400 et seq. 34 C. F. R. 300 (Regulations) PL 108-446

Kaufman, A. S. (2010a). "In what way are apples and oranges alike? A critique of Flynn's interpretation of the Flynn Effect. *Journal of Psychoeducational Assessment, 28,* 382-398.

Kaufman, A. S. (2010b). Looking through Flynn's rose-colored scientific spectacles. *Journal of Psychoeducational Assessment, 28,* 494-505.

Koegel, P., & Edgerton, R. B. (1984). Black "six hour retarded children" as young adults. In R. B.

Edgerton (Ed.), *Lives in process: Mildly retarded adults in a large city* (pp. 145-171). Washington, DC: American Association on Mental Deficiency.

Loeb, P. A. (1996). *Independent Living Scales Manual.* San Antonio, TX: Psychological Corporation, Pearson.

Luckasson, R., Borthwick-Duffy, S., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., Reeve, A., Schalock, R. L., Snell, M. E., Spitalnik, D. M., & Spreat, S., & Tasse, M. J. (2002). *Mental retardation: Definition, classification, and systems of support* (10th Ed.)

Washington DC: American Association on Mental Retardation.

Luckasson, R., Coulter, D. L., Polloway, E. A., Reiss, S., Schalock, R. L., Snell, M. E., Spitalnik, D. M., & Stark, J. A. (1992). *Mental retardation: Definition, classification, and systems of support* (9th Ed.) Washington DC: American Association on Mental Retardation.

Masten, A.S. (2014). *Ordinary magic: Resilience in development.* New York: Guilford Press.

Peltopuro, M., Ahonen, T., Kaartinen, J., Seppala, H. & Narhi, V. (2014). Borderline intellectual functioning: A systematic literature review. *Intellectual and Developmental Disabilities, 52,* 419-443.

Pietschnig, J., & Voracek, M. (2015). One century of global IQ gains: A formal meta-analysis of the Flynn Effect. *Perspectives on Psychological Science, 10, 282-306.*

Reiss, S., & Szyszko, J. (1983). Diagnostic overshadowing and professional experience with mentally retarded persons. *American Journal of Mental Deficiency, 87,* 396-402.

Reschly, D. J. (1987). Learning characteristics of mildly handicapped students: Implications for classification, placement, and programming. In M. C. Wang, M. C. Reynolds, & H. J. Walberg (Eds.), *The handbook of special education: Research and practice* (Vol. I) (pp. 3558). Oxford, England: Pergamon Press.

Reschly, D. J. (1992). Mental retardation: Conceptual foundations, definitional criteria, and diagnostic operations. In S. R. Hooper, G. W. Hynd, & R. E. Mattison (Eds.), *Developmental disorders: Diagnostic*

criteria and clinical assessment (pp. 23-67). Hillsdale, NJ: Lawrence Erlbaum Associates.

Reschly, D. J. (2013). Assessing mild intellectual disability: Issues and best practices. In D. H.

Saklofske, C. R. Reynolds, & V. L. Schwean, & (Eds.). *The Oxford handbook of child psychological assessment* (pp. 683-697). New York: Oxford University Press.

Reschly, D. J. (2014). Identifying and treating educational disabilities. In I. B. Weiner & R. K. Otto (Eds.). *Handbook of forensic psychology (4th 11 ed.) (pp. 197-218).* New York: John Wiley.

Reschly, D. J., & Hosp, J. L. (2004) State SLD policies and practices. *Learning Disability Quarterly, 27, 197-213.*

Reschly, D. J., Myers, T. G., & Hartel, C. R. (Eds.) (2002). *Mental retardation: Determining eligibility for social security benefits.* Washington DC: National Academy Press. http://www.nap.edu/catalog/10295.html?se_side

Reynolds, C. R., & Kamphaus, R. W. (2015). *Reynolds intellectual assessment scales and Reynolds intellectual screening test: Professional manual.* Lutz, FL: Psychological Assessment Resources.

Reynolds, C. R., Niland, J., Wright, J., & Rosenn, M. (2010). Failure to apply the Flynn

Correction in death penalty litigation: Standard practice of today maybe, but certainly malpractice of tomorrow. Journal of Psychoeducational Assessment, 28(5), 477-481.

Richardson, S. (1981). Family characteristics associated with mild mental retardation. In M. Begab, H. C. Haywood, and H. Graber (Eds.),

Psychosocial influences in retarded performance, Volume II (pp. 29-43). Baltimore: University Park Press.

Schalock, R. L., Borthwick-Duffy, S. L., Bradley, V. J., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., Gomez, S. C., Lachapelle, Y., Luckasson, R., Reeve, A., Shogren, K. A., Snell, M. E., Spreat, S., Tasse, M. J., Thompson, J. R., Verdugo-Alonso, M. A., Wehmeyer, M. L., & Yeager, M. H. (2010). *Intellectual disability: Definition, classification, and system of supports (11th Ed.*). Washington D. C.: American Association on Intellectual and Developmental Disability.

Schalock, R. L., Buntinx, W. H. E., Borthwick-Duffy, S. L., Luckasson, R., Snell, M. E., Tasse, M. J., & Wehmeyer, M. (2007). *User's guide: Mental retardation definition, classification, and systems of support.* Washington DC: American Association on Intellectual and Developmental Disabilities.

Schalock, R. L., Luckasson, R., Bradley, V., Buntinx, W., Lachapelle, Y., Shogren, K. A., ...Wehmeyer, M. (2012). *User's guide: Mental retardation definition, classification, and systems of support.* Washington DC: American Association on Intellectual and Developmental Disabilities.

Shrank, F. A., Mather, N., & McGrew, K. S. (2014). *Woodcock-Johnson IV Tests of Achievement.* Rolling Meadows, IL: Riverside Publishing.

Snell, M. E., & Luckasson, R. with Borthwick-Duffy, S., Bradley, V., Buntix, W. H. E. .....Yeager, M. H. (2009). Characteristics and needs of people with intellectual disability who have higher IQs. *Intellectual and Developmental Disabilities, 47,* 220-233.

Sparrow, S. A., Balla, D. A., & Cicchetti, D. V. (2005). *Vineland-II Adaptive Behavior Scales* (2n[d] Ed.). Minneapolis, MN: Pearson.

Spitz, H. H. (2006). How we eradicated familial (hereditary) mental retardation. In H. N. Switzky & S. Greenspan (Eds.) *What is mental retardation? Ideas for an evolving disability in the 21st century* (pp. 81-92). Washington DC: American Association on Intellectual and Developmental Disabilities.

Trahan, L. H., Stuebing, K. K., Fletcher, J. M., & Hiscock, M. (2014). The Flynn Effect: A meta-analysis. *Psychological Bulletin, 140, 1332-1360.*

Wechsler, D. (1997). *Wechsler Adult Intelligence Scale-Third Edition.* San Antonio, TX: Psychological Corporation.

Wechsler, D. (2008a). *Wechsler Adult Intelligence Scale-Fourth Edition.* San Antonio, TX: Psychological Corporation.

Wechsler, D. (2008). *Technical and Interpretative Manual: Wechsler Adult Intelligence Scale-Fourth Edition.* San Antonio, TX: Psychological Corporation.

Weiss, L. G. (2010). Considerations on the Flynn Effect. *Journal of Psychoeducational Assessment, 28,* 482-493.

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PSYHOLOGICAL EVALUATION

NAME: Smith, Joseph Clifton
DATE OF BIRTH: [redacted]
AGE: 28
MARITAL STATUS: Single
REFERRED BY: Greg Hughes, Attorney-at-Law
DATE OF REPORT: 9/6/98

REASON FOR REFERRAL:

Mr. Greg Hughes referred Mr. Smith for an evaluation to obtain psychological information that might be helpful in his defense against charges of burglary, robbery, murder and receiving stolen property.

PERTINENT HISTORY:

Mr. Joseph Clifton Smith is a single, 28 year-old male who was born in Baldwin County. He has four siblings. His mother, Mrs. Glynnis Smith reports that her pregnancy was normal and she denies using any alcohol or drugs while pregnant with Mr. Smith. He was delivered without complications and there were no episodes of unusual illnesses or injuries while he was growing up. He developed normally, walking at approximately one year and talking at two years-old. Both Mr. Smith and his mother similarly described the father as an abusive alcoholic. The father, Mr. Leo Smith is now in his 50's and lives at the Hi-Way Host Motel on Highway 90 in Mobile, Alabama. Reportedly his father is able to maintain gainful

employment inspite of the fact that he remains an active alcoholic. The father was physically and verbally abusive to both his son and wife. Mrs. Smith finally got to the point where she could no longer tolerate the abuse and was able to build up the courage to separate from him.

The divorce between the parents was finalized when Mr. Joseph Smith was approximately 10 years-old. At the time Mr. Smith elementary school and was having alot of problems. Starting in the first grade he was described as a Slow learner. In the fourth grade, during the period when his parents were divorcing; he was tested by the school board and was placed in a learning disability class After that he started getting into more trouble. His temper seemed to flare up unpredictable and he would get into fights frequently. Ultimately his behavior became so troublesome he had to be placed in an emotionally conflicted classroom.

Mr. Smith's mother remarried not too long after she divorced his father. She married Mr. Hollis Luker. Mr. Smith claims it, to was a bad marriage. Mr. Luker was "always running from the law" and he claims that after his mother finally divorced him he was put in prison. Mr. Smith reports that he was treated even more severely by Mr. Luker than his father. Mr. Luker was volatile and abusive, and would physically attack all members of the family including Mr. Smith's other siblings. However, his siblings had an advantage because they were older and in fact, he remembers that his oldest sister moved out soon after her mother married Mr. Luker.

The mother agrees with her son's description of Mr. Luker. She claims that she finally divorced him when he hit her son (Mr. Smith) "up side the head

with a stick" to the point that it almost tore his entire ear off.

After Mr. Luker moved out things were not quite as volatile but the mother claims that her son started to get into more trouble. He was extremely frustrated with school because he was failing in most subjects. Furthermore, while married to Mr. Luker, the family moved almost every year. The mother remembers that her son became increasingly more angry that he had to repeatedly adjust to new schools and sometimes to more than one new school in a year. With his learning problems coupled with being in emotionally conflicted classes, Mr. Smith found it extremely embarrassing when he started each new school. It also got to the point where he quit all efforts towards making friends because he knew that eventually he would be moving away and would have to go through the pain of separating from them. Consequently, he spent most of his early adolescence as a loner, doing poorly in school without developing any sense of competence or mastery in either academics or in making friends. As he got older, his frustration became more evident. He was volatile at home but never physically abusive towards any of his family. He kept violating the family rules and would act out. Eventually, he was taken to the Mobile County Youth Center where he was charged with vandalism, which involved spraying paint on personal property and menacing another person. He was put on probation but lie worked his way off successfully without any major complications.

Mr. Smith admits that his problems got worse over the years due to his alcoholism. He began drinking alcohol regularly at about age 13 or 14 years-old. Right from the beginning he noticed that it created a

"good and calming feeling" inside of him. However, at times he would drink to excess and he would get in trouble, usually by fighting. He denies though that he ever got into using any other drugs. He claims that he has never tried marijuana and he adamantly denies that he ever used crack cocaine or methamphetamine. However, his general negative attitude and tendency to "party and drink" brought him into contact with alot of other youths who had drug problems. At he got older his drinking got progressively worse but he did not ask for help, nor did he agree to get help for his behavior when it was suggested by others. Instead, he continued in his ways until he eventually quit school in 1984 when he was approximately 15 years old. School had become too frustrating and he was making failing grades. He worked briefly for his stepfather but that did not go very well because they could not get along. His first major legal problem occurred when he was 20 years-old. He was charged with Third Degree burglary and receiving stolen property. He was given a 10 year sentence with the understanding that he could split it after spending 180 days in prison. After 180 days he was to be transferred to bootcamp, followed closely thereafter by parole. However, it gets somewhat confusing at this point. He claims that the sentence, as ordered by the judge, was never carried out. Just as he got ready to be released to go to bootcamp he was "bitten by a spider" and he had to stay at Draper Prison while they treated him. The spider bite occurred in the early 1990's and he claims he was not released from jail until January, 1996 and never did go to bootcamp. As he puts it, he spent 6 years in jail when he should have been there only 6 months followed by bootcamp.

Mr. Smith was out of jail for nearly one year when he was sent back on a violation of probation for theft. He was released in November, 1997 and it was only a couple of days after his release that he ended up being charged with his recent offenses. He readily acknowledges that he is drawn to people who only bring the worse out in him. He states further that he usually does not know the people very well with whom he gets into trouble. In general, he claims that he has never had any close relationships and usually would end up just "hanging around with whoever was there."

While in the Alabama State Prison System, Mr. Smith was a regular patient of the medical clinic. Records indicate that he was seen in the medical clinic as many as two or three times a week for all types of medical conditions, many of which seem to be psychosomatic in nature. Most often he complained of [redacted]. He did have some other fairly serious problems. For instance, he suffered from rather [redacted]. He was also cut and stabbed on one occasion. There was another problem that he continually used as a means of getting to the medical clinic. Apparently, when he was a young child his brother poured gas on his feet and he got too close to a fire which ignited the gas. The result was a rather serious burn on his foot and ankle. Mr. Smith claims that the burn was treated inadequately by his parents at the time and that while he was in prison he continued to have trouble with symptoms related to the burn. For instance, he claimed that it regularly became bloated with fluid and that it ached quite a bit.

Mr. Smith also reported alot of emotional problems while he was in prison. None of them seemed to be

psychotic in nature. He never reported having any hallucinations or delusions other than claiming that on two occasions he thought he heard his young female cousin talking to him, asking him to "play with her." He also had several occasions when he thought he heard other people were calling his name. However, his greatest complaint was a chronic state of anxiety with extreme difficulty in sleeping. As a result, a psychiatrist in the state prison system worked with him over several months, trying him on several medications. [redacted].

While in prison, and also while in Mobile Metro Jail, Mr. Smith has had ongoing social problems. He often has complaints about other inmates, soma of which are legitimate. He claims that several of the inmates were finding ways to procure steel objects that they were using to make knives. Mr. Smith ended up reporting these observations to the prison officials and as a result he was beat up on two occasions by other inmates. For a short period of time he was placed outside of the general population in protective custody. At this time, he is back in the general population and states that he is frightened for his life. In discussing his fears, he clearly shows signs of anxiety and suspiciousness but there does not seem to be any paranoid qualities to his stories that might suggest a psychotic distortion of reality.

Other than the medical history as described above, Mr. Smith has not experienced any other significant problems. The most major events include being struck on the head on numerous occasions and several times he lost consciousness briefly; however, there has been no evidence to suggest that these injuries led to organic problems. Mr. Smith denies any major illnesses or sustained high temperatures. He claims further that although he was the object of alot of physical abuse while growing up, he was never sexually abused. He does state though, that he has engaged in heterosexual relationships but denies any homosexual activity. He has never been married and has no children. The few heterosexual relationships he had were typically troublesome. In fact, he recounts his last relationship ended when his girlfriend struck him in the face with a beer bottle and he had to defend himself physically.

ASSESSMENT DEVICES:

Clinical Interview, Wechsler Adult Intelligence Scale - Revised (WAIS-R), Wide Range Achievement Test - Revised 3 (WRAT-3), Bender Gestalt Visual-Motor Integration Test, Projective Drawings, Rorschach, Incomplete Sentences Blank, Mooney Problem Checklist, Minnesota Multiphasic Personality Inventory - 2 (MMPI-2), Millon Clinical Multi-Axial Inventory - III, Subtle Alcohol Screening Survey Inventory - 2 (SASSI-2), Jesness Inventory

CLINICAL INTERVIEW FINDINGS:

Mr. Joseph Smith was interviewed and evaluated on three different occasions at the Mobile County Metro Jail. During two of the three sessions he appeared poorly groomed. During the last session he seemed somewhat better groomed although it was

apparent he did not seem to care much about taking care of himself.

Mr. Smith showed no signs of resistance or defensiveness towards the evaluation process. There was no evidence of suspiciousness about the purpose of the evaluation. It was thoroughly explained to him that everything he said would be put in a report that ultimately would be distributed among court personnel, meaning that it would not be confidential. He stated that he understood the conditions of the evaluation and signed a consent form agreeing to continue with the evaluation.

During the interview, Mr. Smith was alert and oriented. He knew the day, date and time. He was also able to recount the charges against him and ultimately what could happen to him if he were found guilty. He was able to accurately define the role and purposes of all the parties involved in the trial proceedings including the judge, jury, district attorney and defense attorney. There was no doubt that he was mentally competent and capable in assisting his attorney in his defense. Further questioning also showed that he knew right from wrong. Although not alot of time was spent on the details of the actual charges, it was clear that he understood the illegality of events involved. He denied however, the accusations regarding his involvement as reported in the police report. His responses showed not only that he knows right from wrong but also, at the time these events occurred, he was competent and in control of his faculties. He did acknowledge having drunk several beers on the afternoon of the event but he states that he was not intoxicated and was in full control of his faculties.

During the course of the examination, Mr. Smith maintained a flat and unchanging affect. He lacked spontaneity in both his speech and his emotional expressiveness. His behavior was consistent with his mood which he described as depressed. He also reported that he generally worries alot and remains in a constant state of anxiety. Without much probing he offered the opinion that he was not currently suicidal but should he be found guilty he claimed he would be at high risk for finding some way to end his life rather than spend his life in jail or living on death row. Mr. Smith's thinking was coherent and for the most part logical. At times is was necessary to re-state questions in more elementary forms so that he could understand them. His comprehension is limited and it is clear that he lacks much insight or awareness into his behavior. During the course of the interview and test administrations there were no signs of psychotic behavior or deviations from reality. When he did not understand a question, he was not reluctant in asking for clarification. He even went so far as to ask for clarification several times so that he could answer questions to the best of his ability.

During the administration of the tests, Mr. Smith maintained a fairly good attitude and seemed to put forth his best effort, showing fairly good persistence. However, he struggled at times in understanding some of the tasks which required repeating the instructions on several occasions. Inspite of that, it was determined that the test results were valid. There were several tests that he had to read and answer on his own but he was supervised closely to make sure that he understood the content of each question.

COGNITIVE TEST RESULTS:

Mr. Smith was administered the WAIS-R to get an assessment of his intellectual abilities. On the WAIS-R he earned a Verbal IQ of 73, a Performance IQ of 72 and a Full Scale IQ of 72 which places him at the 3rd percentile in comparison to the general population. These scores placed him in the Borderline range of intelligence which means that he operates between the Low Average and Mentally Retarded range. Actually these scores place him at a level closer to those individuals who would be considered mentally retarded.

Analysis of the specific subtests of the WAIS-R showed that Mr. Smith displayed major deficiencies in areas related to academic skills. He functioned well below average in his recall of learned and acquired information (Information). He was also quite weak in word-knowledge and usage (Vocabulary) and mental mathematical computation (Arithmetic). Other areas of noted weakness had to do with his social skills. He scored well below average in skills having to do with social reasoning and learning how to respond effectively in social situations (Comprehension). He also showed a major deficiency in his ability to predict social sequences of action (Picture Arrangement).

Mr. Smith's WAIS-R subtest scores are as follows:

VERBAL SUBTESTS

Information	3
Digit Span	7
Vocabulary	5
Arithmetic	5
Comprehension	5
Similarities	6

PERFORMANCE SUBTESTS

Picture Completion	4
Picture Arrangement	5
Block Design	6
Object Assembly	8
Digit Symbol	4

Mr. Smith was administered the WRAT-3 which is an achievement test used for assessing his scholastic abilities. The results from the WRAT-3 are as follows:

	Standard Score	Percentile	Grade Equivalent
Reading	69	2	4
Spelling	63	1	3
Arithmetic	<45	<.02	Kinder-garten

These scores show that Mr. Smith is barely literate in reading. Usually if you can read at the 4th or 5th grade level you are able to comprehend at least some of what is written in the newspaper. As for spelling, he is slightly more limited and when it comes to arithmetic he is able to do little more than basic addition and subtraction. Operating with skills at this level will make it difficult for Mr. Smith to apply for most meaningful jobs. He particularly could not apply for any job that would require any level of competence in math.

Mr. Smith was administered the Bender Gestalt which assesses visual-perceptual skills as integrated with motor coordination. This test is also used as a gross estimate for ruling out minimal brain dysfunctioning. On the Bender Gestalt, Mr. Smith did fairly well, although he did commit some errors that are typical of individuals at his level of intellectual

functioning. Usually individuals who function in the Borderline to Mental Retardation range, and have learning disabilities, are considered to have minimal organic problems and in some respects that effects not only their ability to learn but also their emotional control.

As a cautionary note though, the Bender Gestalt is not the most reliable test for ruling out organic problems. In order to get a more accurate and thorough picture of such problems he would need to be tested by a much more comprehensive neuro-psychological instrument.

EMOTIONAL FUNCTIONING:

The testing pertaining to emotional functioning showed that Mr. Smith understood the questions and was open in sharing his thoughts and feelings in a fairly direct way. As a result the findings are felt to be a valid representation of his current level of functioning.

The test results showed a pattern consistent with chronic levels of depression. Mr. Smith has been so consumed with worry, anxiety, social sensitivity and mistrust going back to an early age that he has never learned how to find much pleasure in life. Both the testing and the clinical interview findings indicate that he has experienced suicidal ideations on a number of occasions and in the past actually made some attempts. At one point, while in prison, he made a suicidal attempt by cutting his wrist but it was not life threatening. Mr. Smith's emotional problems, which seem to be largely due to an extremely dysfunctional life, are compounded by his mental dullness. This makes his ability to deal with everyday stresses and demands difficult. He presents

an indifferent and ineffectual state of mind. He is not psychotic or out of touch with reality but his thinking is not real clear and he lacks any direction or goal in life. As a result he takes little notice of things around him unless it is intended to protect him from potential harm. He does not think through things. This mind-set provides little basis for acting in a consistently sensible manner or learning from experience. He does not seem to learn from experience even when it involves bringing on pain to himself or those closest to him. In essence, his thinking is vague, easily confused and he is often overwhelmed with incomprehensible feelings or impulses that he does not understand.

PERSONALITY FUNCTIONING:

Mr. Smith's personality functioning is equally dysfunctional. Many of the worries that effect him emotionally come from interpersonal issues, such as having fears of being misunderstood, unfairly judged, manipulated, deceived or hurt. To protect himself he has reduced or narrowed his involvements with others which leaves him feeling lonely and empty. When he withdraws from others it does not necessarily reduce the stress as much as it increases his self-doubt, self-criticism and obsessive worrying about how he feels left out in life. Occasionally he will become desperate enough that he will set out to find people to be with but his low self-esteem and poor judgement causes him to end up with the wrong people. Even if he finds people who are fairly good, he is deeply mistrusting and socially ill-suited to sustain a relationship so he ultimately ends up feeling hurt or misunderstood. As a result it adds to his anger about being rejected and "getting a raw deal in life." Anger has been a major part of his life. Fortunately,

he has been successful at repressing his anger but there is a down side to that. Sooner or later when his anger builds up, it will come out and it will probably come out explosively. In some respects he has relied on alcohol to help in self-medicating against his anger, discontent, anxiety and depression.

CRIMINAL CHARACTERISTICS

In putting together the test findings, Mr. Smith is not someone who displays the typical characteristics of a criminal or psychopathic personality. Rather, his thinking and judgement is vague and he displays poor judgement, limited ego strength, a lack of direction in life and he is generally ineffective in problem-solving. When he does engage in criminal activity it will most often be based on impulsive thinking led by a lack of judgement. He fails to use good judgement because he has never learned how to incorporate successfully into societies norms. More-over, he is drawn to others of similar character who he will follow into criminal activity. Planning or carrying out criminal activity on his own is rather unlikely.

DIAGNOSTIC IMPRESSION:

AXIS I:

1. Major Depression, severe without Psychotic Features - 296.23
2. Post-Traumatic Stress Disorder, Chronic, Due to Early Childhood Trauma - 309.81
3. Alcohol Dependence, In remission by incarceration - 303.90
4. Learning Disorder, NOS - 315.9
5. Personality Disorder, NOS with Schizotypal and Antisocial Features - 301.9
6. Borderline Intellectual Functioning - V62.89

CONCLUSIONS:

Mr. Smith is certainly not without his faults and responsibilities but he has endured alot of mistreatment in his life, starting in his formative years which makes it very hard to change these patterns. The testing shows that he feels alone and empty which is typical of individuals brought up in a disruptive, threatening and unprotected environment. Prognosis for major change is not good. Should he ever get out of jail he needs to be involved in a long-term half-way house where his alcohol dependence can be treated and he can learn how to work and cope in the world.

It should also be noted that Mr. Smith is a high suicide risk, especially if found guilty of capital murder. Although in some respects he could use such behavior in a manipulative and attention-seeking way, he possesses extremely limited insight and judgment so that he could well hurt himself without giving it much thought.

/s/ James F. Chudy
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JFC/sww