No. 12-10882

In the Supreme Court of the United States

FREDDIE LEE HALL,
Petitioner,

v.

STATE OF FLORIDA,
Respondent.

On Writ of Certiorari to the
Florida Supreme Court

BRIEF FOR RESPONDENT

CAROLYN M. SNURKOWSKI
Associate Deputy Attorney General

CAROL M. DITTMAR
Senior Assistant Attorney General

DIANE G. DEWOLF
RACHEL E. NORDBY
LEAH A. SEVI
OSVALDO VAZQUEZ
Deputy Solicitors General

PAMELA JO BONDI
Attorney General of Florida

ALLEN WINSOR
Solicitor General
Counsel of Record

Office of the
Attorney General
PL-01, The Capitol
Tallahassee, Florida 32399
allen.winsor@
myfloridalegal.com
(850) 414-3300

QUESTION PRESENTED

In *Atkins v. Virginia*, 536 U.S. 304 (2002), this Court held that the Eighth Amendment prohibits the execution of the mentally retarded. Citing evidence primarily consisting of State statutes (including the Florida statute at issue here), the Court found a nationwide consensus supporting the prohibition. The Court noted that, "[t]o the extent there is serious disagreement about the execution of mentally retarded offenders, it is in determining which offenders are in fact retarded," and expressly "le[ft] to the states the task of developing appropriate ways to enforce the constitutional restriction." *Id.* at 317.

The question presented is whether the Eighth Amendment requires Florida to use a clinical definition of mental retardation, including incorporation of a "standard error of measurement" for intelligence tests, in its framework for identifying which offenders are exempt from the death penalty under *Atkins v. Virginia*.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

Other Authorities

INTRODUCTION

Petitioner Freddie Lee Hall was convicted of murdering Karol Hurst, a pregnant, twenty-one year old newlywed. He was separately convicted of murdering sheriff's deputy Lonnie Coburn, who encountered Hall shortly after Hurst's murder. Seeking to avoid execution, Hall claims he is mentally retarded and ineligible for the death penalty under *Atkins v. Virginia*, 536 U.S. 304 (2002). Hall makes no claim that he satisfies Florida's definition for mental retardation, insisting instead that Florida's definition must yield to medical or clinical criteria. But clinicians do not make Eighth Amendment determinations, and Florida's law is an appropriate means of enforcing *Atkins*. Moreover, the record of Hall's mental capacity, accumulated in over three decades of legal proceedings, shows that the State accurately determined that Hall is not "so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus." *Id.* at 317.[1]

STATEMENT OF THE CASE

A. Hall's Crimes and Mental Ability

After robbing several convenience stores over a period of weeks in 1978, Hall and his accomplice, Mack Ruffin, planned to rob again. 1993 Appeal ROA

[1] Consistent with the constant change in the field, there has been a recent shift in terminology, and the term "intellectual disability" now prevails. *See* Pet'r Br. 1 n.1. To maintain consistency with Petitioner's brief and the decisions below, this Brief uses "mental retardation."

v.9 R.1606, v.4 R.614;[2] JA8-9. They sought a car to use in their crime, and Karol Hurst, whom they saw walking out of a grocery store, had one. So Hall kidnapped her. He then drove Hurst's car (with Hurst in it) to a wooded area, with Ruffin following in another car. After Hurst begged for her life and the life of her unborn child, Hall and Ruffin beat her, raped her, and killed her. JA8-10; 1993 ROA v.9 R.1505-06.

Then equipped with a getaway car, the men went to the store they planned to rob. Once inside, though, they found too many customers and aborted the robbery. Meanwhile, a suspicious store clerk alerted authorities, and Deputy Coburn responded to the scene. JA9. Outside the store, Deputy Coburn approached the men and attempted to frisk them. Hall then grabbed Coburn, a struggle ensued, and Coburn was shot and killed. 1993 ROA v.9 R.1509-10. Hall and Ruffin immediately fled the scene, with Hall driving and Ruffin shooting at pursuing officers. JA9, 42-43, 56-57.

After their apprehension, both men provided accounts blaming the other for the crimes. *Compare Ruffin v. Dugger*, 848 F.2d 1512, 1514 (11th Cir. 1988) (per curiam), *with Hall v. Dugger*, 531 So. 2d 76, 77 (Fla. 1988); *see also* Pet'r Br. 8-9.

---

[2] Pursuant to the Florida Rules of Appellate Procedure, the Florida Supreme Court's review of Hall's case included records associated with his previous appeals. *See* FLA. R. APP. P. 9.142(a)(1). References to materials not reproduced in the Joint Appendix are identified by the associated Florida Supreme Court appeal.

The 1978 kidnapping, rape, and murders were not Hall's first crimes. A decade earlier, he was convicted of assault with intent to commit rape—a crime in which he gouged his victim's eyes hoping to prevent his identification. 1993 ROA v.9 R.1476-77. (Although Hall received a twenty-year sentence, *id.*, he was paroled in time to commit the 1978 rape and murders, JA31.) The 1968 conviction supported one of three aggravating factors in Hall's original sentence for Hurst's murder; the others were that he committed the murder during the commission of kidnapping and robbery and that the murder was especially heinous, atrocious, or cruel.[3] JA14.

Throughout the next three decades, Hall filed multiple appeals, habeas petitions, and motions to overturn his sentence. For ten years, he asserted no claim based on mental retardation. Indeed, Hall was found to have "intelligence [] within the average range" in a pretrial evaluation two months after the murders.[4] 1993 ROA v.12 R.1956-59. Hall did claim diminished capacity to appreciate the criminality of his conduct, though he based that claim on drug use.

---

[3] In Hall's 1990 resentencing, the court found four additional aggravating factors: that the crimes were i) committed while Hall was on parole for the 1968 assault; ii) committed for pecuniary gain; iii) cold, calculated, and premeditated; and iv) committed to avoid arrest. JA30-34.

[4] During this evaluation, Hall reportedly told the court-appointed doctor that he had "put it on like I was crazy" during a 1965 military physical, after which he was rated 4-F for low intellectual capacity. 1993 ROA v.12 R.1952-53; *id.* v.1 R.367 (1968 Pre-Sentence Report) ("[Hall] claimed . . . he played dumb to stay out of the service"). Hall's experts later testified that they doubted his ability to fool the draft board. *Id.* v.11 R.1767-68.

JA13. Hall also repeatedly argued that the evidence was insufficient to show that he intended Hurst's death, contending that Ruffin alone raped, beat, and murdered Hurst. Courts unanimously rejected this argument. *See* JA10; *Hall v. State*, 420 So. 2d 872, 874 (Fla. 1982); *Hall v. Wainwright*, 733 F.2d 766, 770-71 (11th Cir. 1984), *cert. denied*, 471 U.S. 1107 (1985).

In 1988, for the first time, Hall claimed mental retardation. Following *Hitchcock v. Dugger*, 481 U.S. 393 (1986), the Florida Supreme Court ordered a new sentencing to allow evidence of all mitigating factors, including mental retardation. JA17-22. After a six-day proceeding in December 1990, another jury again recommended a death sentence, and another judge again accepted the recommendation. In a detailed, 32-page order, Judge Tombrink noted that the evidence of mental retardation was largely uncontroverted but expressed skepticism of Hall's experts who "were guilty of some professional overkill." JA42. He concluded that the experts' assessments were inconsistent with facts in the record and could not explain "how a psychotic, mentally-retarded, brain-damaged, learning-disabled, speech-impaired person" could: i) formulate the plan for the theft of the car and the aborted store robbery; ii) kidnap Hurst and drive her through Leesburg and to the murder site; iii) drive the getaway car after Coburn's murder in a successful effort to evade police; iv) evade the initial manhunt; v) before the crime, live a more or less normal life for five years on probation for his 1968 conviction; or vi) make the statements he made when he testified at his first trial, which focused on blaming others and were "no different than those made by the 'normal' defendant in almost any criminal trial con-

ducted." JA42-43. Nevertheless, Judge Tombrink concluded that Hall had established mental retardation as a mitigating factor under *Penry v. Lynaugh*, 492 U.S. 302 (1989).[5] But he concluded that the mitigators did not outweigh the aggravators.[6]

Hall's latest claims regarding his mental status came after Florida enacted section 921.137 and this Court decided *Atkins*.[7]

---

[5] "[M]ental retardation for purposes of *Atkins*, and mental retardation as one mitigator to be weighed against aggravators, are discrete issues." *Bobby v. Bies*, 556 U.S. 825, 829 (2009). Regardless, at the resentencing stage, "Hall's evidence [regarding mental retardation] went unchallenged, whereas in 2010, there was a true adversarial testing of whether Hall was mentally retarded under Florida's statutory definition of mental retardation." JA129 (Pariente, J., concurring).

[6] In appealing this order, Hall highlighted, as he does here, that Ruffin eventually received a life sentence for murdering Hurst. *See* Pet'r Br. 9. But as the Florida Supreme Court noted, Ruffin was younger than Hall, had no criminal history, and, unlike Hall, was not on parole for a violent crime at the time of the murder. JA71-72.

[7] In the interim, Hall filed another post-conviction motion, alleging (among other things) that he was not competent at resentencing. At a hearing, again before Judge Tombrink, Hall's attorney from the resentencing provided testimony regarding this claim. Significantly, he testified that the legal team made a strategic decision not to present testimony from Dr. Harry Krop, an evaluating expert, because Dr. Krop learned more about the facts of the crimes than did other experts and found that some aspects of his evaluation of Hall "did not equate into certain of the actions" of the crimes. 1999 ROA v.7 Tr.252. The court rejected the incompetency claim, with Judge Tombrink giving "great weight" to his opportunity to observe Hall and hear from

B. Florida's Means for Identifying Mentally Retarded Defendants

In 2001, the year before *Atkins*, Florida enacted a statute prohibiting the execution of the mentally retarded. Rather than create a new definition, the new law adopted nearly verbatim a definition from longstanding Florida law regarding treatment for the mentally retarded. *See* Fla. S. Comm. on Crim. Justice, CS for SB 238 (2001) Staff Analysis 11 (Feb. 14. 2001) ["Senate Staff Analysis"]; *see also* FLA. STAT. § 393.063 (2013). This definition requires a showing of: "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the period from conception to age 18." FLA. STAT. § 921.137(1) (2013). The statute further defines "significantly subaverage general intellectual functioning," as "performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the Agency for Persons with Disabilities." *Id.*

Section 921.137 expressly applied only to those sentenced after its effective date. *Id.* § 921.137(8). But following *Atkins*, the Florida Supreme Court promulgated Florida Rule of Criminal Procedure 3.203, which governs all *Atkins* claims and incorporates that statute's definition. *See* Fla. R. Crim. P. 3.203(b); *see also* JA120. Under Rule 3.203, a defendant must provide the reports of any expert evaluations, and the court may appoint experts to conduct additional evaluations. *Id.* R. 3.203(c)(2). If there has been no

---

him at various proceedings. JA86. The Florida Supreme Court affirmed. JA91.

evaluation, the court must appoint two experts to conduct them. *Id.* R. 3.203(c)(3). The court must then conduct an evidentiary hearing and consider the experts' findings "and all other evidence on the issue of whether the defendant is mentally retarded." *Id.* R. 3.203(e). To prevail, the defendant must prove mental retardation by clear and convincing evidence. *Franqui v. State*, 59 So. 3d 82, 92 (Fla. 2011).

C. Hall's *Atkins* Hearing and the Court's Ruling

The trial court held a two-day evidentiary hearing on Hall's Rule 3.203 motion. At the outset, it granted the State's motion *in limine* to require Hall to present evidence satisfying the first prong of the statute's three-part definition—significantly subaverage intellectual functioning—before proceeding to the others. JA168. Notwithstanding its motion, the State made clear that it had no objection to Hall's proffering evidence regarding the other two prongs, even though it would be irrelevant absent sufficient proof on the first prong. JA158.

Hall presented evidence relating to all three prongs. *See* JA169-70, 174-77. Dr. Valerie McClain testified regarding the clinical definitions of mental retardation; Lugene Ellis and James Hall testified regarding Hall's upbringing and capabilities as a child; Dr. Krop, who had testified in a 1997 hearing, *see supra* n.7, testified about his 1990 assessment of Hall; and Dr. Gregory Prichard testified about his 2002 assessment and resulting report. *See* JA103-05.[8] In

[8] The court appointed a fourth expert, Dr. Harry McClaren, to assist the State and evaluate Hall. *See* 2012 ROA v.1 R.147-

addition, on Hall's motion, the Court took judicial notice of portions of the 1990 resentencing record. JA171-73.

Regarding the first prong, Hall's records showed the following intelligence scores:

Year	Age	IQ Score
1968	23	76
1979	33	79
1986	41	80
1988	43	60
1990	44	73
1995	50	74
2001	56	69
2002	57	71
2008	63	72

---

50. Dr. McClaren's report noted that Hall described a history of alcohol abuse, used speech that was "coherent and understandable," and discussed possible hallucinations. *Id.* R.149. Dr. McClaren concluded that he could not rule out a cognitive disorder, that Hall operated in the borderline range of intellect, and that "[r]ecent decreases in measured IQ" might be attributable to "changes in his mental condition associated with symptoms of Psychosis." *Id.* R.149-50. Dr. McClaren's report was not introduced into evidence at the hearing.

Hall attempted to introduce a report from a fifth expert, Dr. William Mosman, who examined Hall in 2001 but died before the hearing. The court excluded this report, JA105-07, the Florida Supreme Court affirmed the exclusion, JA125, and Hall does not challenge that ruling here. Hall's reliance on this excluded evidence, *e.g.,* Pet'r Br. 52, is therefore unwarranted.

See JA107-08, 389, 442-50, 512, 525.[9]

The court denied Hall's Rule 3.203 motion. It noted that Doctors Krop and Prichard measured Hall's IQ at 73 and 71, respectively, while the other test scores Dr. Prichard summarized were above 70. The court concluded that Hall did not satisfy the intellectual functioning prong because he could not establish an IQ two standard deviations below the mean. Because Hall had to satisfy all three prongs, that fact alone ended Hall's claim. JA107-09. In an "abundance of caution," though, the court evaluated Hall's evidence on adaptive functioning and age of onset and found that Hall failed to establish either additional prong. JA109-13. Finally, although the standard of proof is clear and convincing evidence, the court stated that its conclusion would be the same under a preponderance-of-evidence standard.[10] JA113-14.

---

[9] The 2001 test (by Dr. Mosman) is not in the evidentiary record. *See supra* n.8. In response to Hall's objection, the court also excluded Dr. Joseph Sesta's 2008 test, but it did accept Dr. Pritchard's inclusion of that score in his analysis. *See* JA107-08, 371. Dr. Pritchard did not rely on the 1988 or 1995 results in his summary. *See* JA108, 442-50.

[10] The court cited multiple factors in support of its findings. First, Hall was required to prove adaptive deficits concurrent with his IQ testing, that is, while incarcerated. JA110 (citing *Phillips v. State*, 984 So. 2d 503, 510 (Fla. 2008)). Hall presented no such evidence. Nor could he, as none of Hall's experts reviewed materials regarding Hall's functioning in prison, and Dr. Pritchard based his analysis on information from decades before. JA109-12; *see also* JA111 (quoting Dr. Prichard's testimony: "I have done adaptive behavior testing with prison guards before, current adaptive testing. I didn't do it in this case. I don't know why I didn't do it . . . But I did not interview a Department of

The Florida Supreme Court affirmed, reiterating that section 921.137 requires an IQ score below 70, and noting that it had repeatedly found the statute consistent with *Atkins*. JA122-24. The court also rejected Hall's arguments that the trial court improperly limited evidence on the other two prongs, *see supra* n.8; JA124-25, and that earlier mitigation findings regarding mental retardation bound the *Atkins* determination. JA125-26 (citing *Bobby v. Bies*, 556 U.S. 825 (2009)).

SUMMARY OF ARGUMENT

In *Atkins v. Virginia*, this Court held that the Eighth Amendment forbids the execution of the mentally retarded. 536 U.S. 304 (2002). Although the Court found a national consensus against the practice generally, it noted there was no consensus about how to determine "which offenders are in fact retarded." *Id.* at 317. Indeed, the Court recognized that "[n]ot all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus." *Id.* Therefore, rather than establish a fixed, national standard to determine which defendants are "so impaired," the Court left "to the States the task of developing appropriate ways to enforce the constitutional restriction." *Id.* (quoting *Ford v. Wain-*

Corrections person.") (ellipses in order). Second, Hall failed to provide sufficient evidence regarding his intelligence before age 18, rendering him unable to satisfy the third prong. JA112-13. Although Hall argues that he put on "overwhelming evidence of mental retardation," Pet'r Br. 18, he does not specifically challenge the trial court's factual findings on these other two prongs.

wright, 477 U.S. 399, 416-17 (1986) (plurality opinion) (marks omitted)).

Florida enforces this restriction through section 921.137, which was among the statutes *Atkins* identified as evidence of a national consensus. *See Atkins*, 536 U.S. at 315, 317 & n.22. Like most of those statutes, and like most clinical definitions, section 921.137 employs a basic, three-part framework for defining mental retardation, requiring showings of deficient intellectual functioning, poor adaptive functioning, and onset before age 18.

Yet according to Hall, Florida's determination violates *Atkins* because the first part of Florida's definition differs from "established clinical definitions." Pet'r Br. 30. Despite decades of consistently scoring above 70 on IQ tests—a widely recognized threshold for mental retardation, *see, e.g., Atkins*, 536 U.S at 308 n.3 ("'Mild' mental retardation is typically used to describe people with an IQ level of 50-55 to approximately 70.")—Hall contends that Florida is constitutionally obligated to apply a five-point error range because professional organizations suggest that approach in the clinical context. But "*Atkins* did *not* establish a national standard for mental retardation," *Allen v. Buss*, 558 F.3d 657, 665 (7th Cir. 2009), and because Florida's standard captures those "so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus," *Atkins*, 556 U.S. at 317, it is faithful to both *Atkins* and the Eighth Amendment.

This case turns on whether *Atkins* truly left any determination to the States or whether, as Hall con-

tends, States are constitutionally bound to vague, constantly evolving—and sometimes contradictory—diagnostic criteria established by organizations committed to expanding *Atkins*'s reach. Nothing in *Atkins* compels the rule Hall advances. "'[T]he Constitution contemplates that in the end [the Court's] own judgment will be brought to bear on the question of the acceptability of the death penalty under the Eighth Amendment,'" *id.* at 312 (quoting *Coker v. Georgia*, 433 U.S. 584, 597 (1977) (plurality opinion)), and the Court has never deferred that independent obligation to third parties. Moreover, this Court has consistently refused to require States to adopt any particular clinical judgment and "ha[s] traditionally left to legislators the task of defining terms of a medical nature that have legal significance." *Kansas v. Hendricks*, 521 U.S. 346, 358-59 (1997). And in areas of mental health science—which is constantly evolving—it has recognized that "courts should pay particular deference to reasonable legislative judgments." *Jones v. United States*, 463 U.S. 354, 364 n.13 (1983).

The issue, then, is not whether Florida and any particular organization's latest publication agree precisely on how to define mental retardation. Instead, the issue—a purely legal one—is whether Florida's determination constitutes an "appropriate way[] to enforce the constitutional restriction." *Atkins*, 536 U.S. at 317 (quoting *Ford*, 477 U.S. at 416) (marks omitted). A fair review of Florida's standard demonstrates that it generally conforms to the clinical definitions and, by promoting administrability and accuracy, advances important state interests. Florida's standard thus constitutes an appropriate way to enforce *Atkins*'s constitutional restriction. Adopting Hall's

unprecedented approach, which supplants Florida's legislative judgment with ever-changing clinical criteria, would undermine these important state interests and go beyond any rule that *Atkins* intended.

Finally, Florida's standard resulted in the correct outcome in this case. Hall's conduct in his crimes and extensive evidence from the record of his appeals refutes his claims of intellectual and adaptive deficits. The trial court was justified in determining that Hall is not entitled to relief under *Atkins*.

ARGUMENT

Florida's method for determining whether a capital offender is mentally retarded is fully consistent with the Eighth Amendment. Part I of this Brief demonstrates that, contrary to Hall's arguments, *Atkins* provides the States ample leeway in defining mental retardation. Part II shows that this Court has traditionally deferred to legislative judgments regarding scientific questions and that Hall presents no reason to abandon that approach here. Part III demonstrates that Florida's standard is an appropriate means of enforcing *Atkins*. Part IV concludes, showing that Hall is not within the category of offenders subject to *Atkins*.

I. *ATKINS* LEFT STATES SUBSTANTIAL LEEWAY IN ENFORCING THE CONSTITUTIONAL RESTRICTION.

In exempting the mentally retarded from executions, this Court found that because of their impairments, those persons "do not act with the level of moral culpability that characterizes the most serious adult criminal conduct." *Atkins*, 536 U.S. at 306.

Although a footnote referenced clinical definitions from the American Association on Mental Retardation ("AAMR") and the American Psychiatric Association ("APA"), the Court's focus was not on any particular diagnostic criteria. Instead, the decision turned on a legislative consensus and the Court's "'own judgment [] brought to bear,'" regarding the imposition of death on those with characteristics shared by those generally considered mentally retarded. *Id.* at 312 (quoting *Coker*, 433 U.S. at 597). It then left to the States the task of establishing appropriate definitions and procedures.

A. *Atkins* Does Not Command Strict Adherence to Any Particular Diagnostic Criteria or Definition of Mental Retardation.

Petitioner and his amici start from the flawed premise that *Atkins* required a *clinical* definition of mental retardation. *See, e.g.*, Pet'r Br. 30, 34. But whether a defendant qualifies for exemption under *Atkins* is a legal issue, *see Bobby v. Bies*, 556 U.S. 825, 836 (2009), and "*Atkins* clearly did not hold . . . that states must employ the AAMR or APA definitions of mental retardation, *let alone that they must employ the same underlying clinical analysis that the AAMR and APA use* to determine which patients meet each prong of those organizations' definitions," *Chester v. Thaler*, 666 F.3d 340, 347 (5th Cir. 2011) (emphasis added), *cert. denied*, 133 S. Ct. 525 (2012). In fact, this Court has never required States to adopt a particular medical definition or particular diagnostic criteria, especially where mental health issues are involved. *See infra* Part II.A.

Thus, notwithstanding Hall's contrary arguments, Pet'r Br. 31, the States' authority in enforcing *Atkins* is not limited to procedural determinations. Indeed, after *Atkins*, this Court explicitly stated that *Atkins* "did not provide definitive procedural *or substantive* guides for determining when a person who claims mental retardation 'will be so impaired as to fall [within *Atkins*' compass].'" *Bobby*, 556 U.S. at 831 (emphasis added; other alterations in original) (quoting *Atkins*, 536 U.S. at 317). The Court reiterated that these determinations were left to the States and even observed that "Ohio heeded *Atkins*' call" when its state supreme court established *substantive* criteria for a successful *Atkins* claim. *Id.*; *accord Atkins v. Commonwealth*, 581 S.E.2d 514, 517 (Va. 2003) (on remand, noting that legislature enacted statutory definition in response to *Atkins*).[11]

Likewise, lower courts have uniformly recognized that state leeway extends to substantive definitions of mental retardation. *See, e.g., Hill v. Humphrey*, 662 F.3d 1335, 1339 (11th Cir. 2011) (en banc) ("In *Atkins*, the Supreme Court was careful not to . . . impose rigid definitions of mental retardation."); *Sasser v. Norris,* 553 F.3d 1121, 1125 n.3 (8th Cir. 2009) ("*Atkins* actually does not define mental retardation, leaving the development of the new constitutional restriction to the states."), *abrogated on other grounds by Wood v.*

[11] Indeed, Hall acknowledged below that, "*[r]ather than adopt a definitive meaning of mental retardation . . .*, [*Atkins*] left to the States the task of developing appropriate ways to enforce the constitutional restriction." Brief of Appellant at 16, No. SC10-1335 (Fla. Dec. 22, 2010) (quoting *Atkins*; marks omitted) (emphasis added).

Milyard, 132 S. Ct. 1826 (2012); *Clark v. Quarterman*, 457 F.3d 441, 445 (5th Cir. 2006) ("[*Atkins*] did not dictate that the approach and the analysis of the State inquiry must track the approach of the AAMR or the APA exactly."); *People v. Jackson*, 199 P.3d 1098, 1110 (Cal. 2009) ("*Atkins* . . . left to the states the tasks of defining mental retardation . . . ."); *Wiley v. State*, 890 So. 2d 892, 894 (Miss. 2004) ("The *Atkins* decision did not define who is or is not mentally retarded . . . .").

Against this weight of authority, Hall relies on *Panetti v. Quarterman*, 551 U.S. 930 (2007), and *Ford v. Wainwright*, 477 U.S. 399 (1986) (plurality opinion), which addressed the categorical prohibition against executing the insane. In Hall's view, *Panetti* held that *Ford* allowed States leeway only in defining *procedures* for implementing the categorical bar. Pet'r Br. 32-33. But this ignores the *Ford* plurality's refusal to impose a definition of insanity on the States, *see* 477 U.S. at 421-22 & n.3 (Powell, J., concurring); *see also Panetti*, 551 U.S. at 957, as well as the *Panetti* Court's own refusal to endorse one test for insanity, *see* 551 U.S. at 960-61; *id.* at 978-79 & n.11 (Thomas, J. dissenting). In the end, Hall confuses *Panetti*'s recognizing some minimum constitutional standard for competence (which it did), with its imposing a nationwide, substantive definition of insanity (which it did not). Likewise, *Atkins* did not set forth a blanket standard tied to the clinical definitions. Indeed, if this Court were to constitutionalize precise and evolving clinical criteria, it would substantially expand the exemption *Atkins* intended, stand at odds with the consensus *Atkins* recognized, and conflict with *Atkins* itself.

B. *Atkins* Relied On a National Consensus That Included Florida and Other States with Varied Definitions of Mental Retardation.

In suggesting that *Atkins* demands state adherence to prevailing clinical criteria, Hall ignores *Atkins*'s reliance on a consensus of state laws, including Florida's law and others like it. According to Hall's logic, the same state statutes that *comprised* a national consensus in *Atkins contradicted* that consensus if they deviated from clinical definitions. *Cf. Stripling v. State*, 711 S.E.2d 665, 669 (Ga. 2011) ("Georgia . . . was counted [in *Atkins*] as being *part of* the national consensus regarding the treatment of mentally retarded defendants, and it seems to us entirely illogical that Georgia could have been part of the consensus dictating a categorical rule and yet somehow simultaneously stand in violation of that same rule."). As the Court recognized in *Atkins,* the national consensus reflected a general determination that mentally retarded persons should not be executed; there was never a national consensus regarding precisely who qualified for the protection *Atkins* provided. 536 U.S. at 317 & n.22.

Barely a dozen years before *Atkins*, the Court rejected the proposition that the Eighth Amendment categorically prohibited executing the mentally retarded. *Penry v. Lynaugh*, 492 U.S. 302, 340 (1989). The Court did not simply change its judgment in the interim; instead, "[m]uch ha[d] changed." *Atkins*, 536 U.S. at 314. States across the country had moved away from these executions, and the dramatic shift "provide[d] powerful evidence" that society had come

to view mentally retarded defendants "as categorically less culpable than the average criminal." *Id.* at 316. Summarizing the States' moves, the Court concluded that executions of the mentally retarded had "become truly unusual, and it is fair to say that a national consensus has developed against it." *Id.*

As evidence of the national consensus, the Court specifically cited Florida's statute at issue here, which has not substantively changed. *Id.* at 315 n.15. And Florida then, as now, was no outlier. *See infra* Part III.B. Instead, like the other States cited in *Atkins*, Florida relied on a three-part framework that "generally conformed with the clinical definitions." 536 U.S. at 317 n.22. To the extent there was consensus on a definition, it extended only to that essential, three-part framework. There was no agreement, then or now, on any clinical diagnostic criteria—that is, the methods by which that framework is applied.

There was no agreement on whether to impose an IQ cutoff and, if so, what the cutoff should be. Of the eighteen state statutes cited in *Atkins*, *see id.* at 314-15, ten established particular IQ scores as eligibility criteria—most, but not all, used 70.[12] There was no

[12] *See* ARIZ. REV. STAT. ANN. § 13-703.02(E) (2001) (current version at § 13-753(F)) (70 or below)); ARK. CODE ANN. § 5-4-618(a)(2) (2001) (rebuttable presumption with IQ below 65); KY. REV. STAT. ANN. § 532.130(2) (West 2001) (70 or below); MD. ANN. CODE § 2-202(b)(1)(i) (2001) (repealed 2013) (70 or below); NEB. REV. STAT. § 28-105.01(3) (2001) (2001) (70 or below is "presumptive evidence" of retardation); 2001 N.C. Sess. Laws p. 45 (codified as N.C. GEN. STAT. § 15A-2005(a)(2) (2002)) (70 or below); N.M. STAT.

agreement on how to measure adaptive functioning. *Compare, e.g.*, WASH. REV. CODE § 10.95.030(2)(d) (2001) (defining adaptive functioning by reference to "standards of personal independence and social responsibility"), *with* N.C. GEN. STAT. § 15A-2005(a)(1)(b) (2002) (requiring specific limitations in two or more of eleven specified skill areas). And there was no agreement on the age of onset. *Compare, e.g.*, N.C. GEN. STAT. § 15A-2005(a)(1)(a) (2002) (age 18), *with* MD. ANN. CODE § 2-202(b)(1)(ii) (2001) (age 22). Beyond these differences in the definitions themselves, there was no agreement on how the definitions would be applied, such as how IQ was to be measured.

There was no uniform agreement because, as Petitioner in *Atkins* explained, each State's determination "is inevitably the product of a unique legislative process, involving participation by a wide array of that State's citizens, including prosecutors, defense attorneys, judges, disability advocates, and other groups." Reply Brief of Petitioner, Atkins v. Virginia, No. 00-8452 at 1 (Feb. 12, 2002). It therefore

---

ANN. § 31-20A-2.1(A) (2001) (repealed 2009) (70 or below is "presumptive evidence" of mental retardation); S.D. CODIFIED LAWS § 23A-27A-26.2 (2001) (70 or above is "presumptive evidence" of absence of mental retardation); TENN. CODE ANN. § 39-13-203(a)(1) (2001) (70 or below); WASH REV. CODE § 10.95.030(2)(c) (2001) (70 or below). Of the remaining states, five used a statutory definition without a score specified, New York did not have a statutory definition, and Connecticut used a standard requiring a score two standard deviations below the mean. *See* CONN. GEN. STAT. § 1-1g(c) (2001); N.Y. CRIM. PROC. LAW § 400.27(12) (2001).

was no surprise that States' "statutory definitions of mental retardation are not identical." 536 U.S. at 317 n.22.[13]

The consensus *Atkins* described was not about a clinical label or medical definition; the consensus was that some defendants are "so impaired" that they should not be executed. *Id.* at 317. Florida—through the very law Hall challenges—helped form that consensus.

C. *Atkins* Also Relied On the Court's Own Judgment, Which Comported with the State Legislative Determinations.

Although the Court did not limit its analysis to the States' decisions, it found "no reason to disagree with the judgment of the legislatures." *Atkins*, 536 U.S. at 321 (marks omitted); *see also Roper v. Simmons*, 543 U.S. 551, 574-75 (2005). The Court's independent judgment centered on two principal considerations: mentally retarded defendants' diminished culpability, and the inapplicability of traditional penological purposes to their executions. *Atkins*, 536 U.S. at 317. The Court found that the mentally retarded "have diminished capacities to understand and

---

[13] In Kansas, one of the states counted within the consensus, an offender's intellectual functioning must have substantially impaired his capacity to appreciate the criminality of his conduct, a standard unlike that of any other state, and one more removed from the clinical definition. *See Atkins*, 536 U.S. at 342-43 & n.2 (Scalia, J., dissenting) (citing KAN. STAT. ANN. § 21-4623(e) (2001) (current version at § 21-6622(h)).

process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others." *Id.* at 318. The Court also found "a serious question" as to whether the recognized justifications for the death penalty apply to the mentally retarded. *Id.* at 319. Their lesser culpability removes the mentally retarded from among "the most deserving of execution." *Id.* And the same deficiencies that make them less morally culpable "make it less likely that they can process the information of the possibility of execution as a penalty and, as a result, control their conduct based upon that information." *Id.* at 320; *accord Roper*, 543 U.S. at 563. Finally, the Court found that the mentally retarded "face a special risk of wrongful execution" because of the possibility of their falsely confessing and their inability to assist counsel or demonstrate mitigating facts. *Atkins*, 536 U.S. at 320-21.

As with the national consensus, the *Atkins* Court's independent judgment turned on characteristics shared by a class of individuals for whom a death sentence would be disproportionate. It did not turn on medical labels in describing which offenders were "so impaired as to fall within" this class. *Id.* at 317. The Court did not impose a one-size-fits-all standard to identify these offenders, instead trusting States to make appropriate determinations in implementing *Atkins*. It should not stop now.

II. THE COURT SHOULD NOT ELIMINATE THE STATES' ROLE IN DEVELOPING APPROPRIATE MEANS OF ENFORCING *ATKINS*.

Hall offers no valid reason for the Court to require every State to not only employ the three-part definition (which Florida does), but, in applying the definition, also adopt the full range of diagnostic criteria endorsed by professional organizations. There are compelling reasons why the Court should not.

A. The Court Has Traditionally Deferred to State Legislative Judgment in Defining Mental Conditions with Legal Significance.

The Court's decision in *Atkins* to defer mental retardation definitions to the States was not unusual. Indeed, the Court "ha[s] traditionally left to legislators the task of defining terms of a medical nature that have legal significance." *Kansas v. Hendricks*, 521 U.S. 346, 359 (1997). States have developed varied definitions for mental health concepts, which often "do not fit precisely with the definitions employed by the medical community." *Id.* The Court has noted, for example, that the legal definitions of "insanity" and "competency" "vary substantially from their psychiatric counterparts." *Id.*; *see also id.* ("Legal definitions . . . need not mirror those advanced by the medical profession.") (citing APA, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS at xxiii, xxvii (4th ed. 1994) ["DSM-IV"]).

The Court has never relied exclusively on the medical community to determine constitutional rules. In *Kansas v. Crane*, decided the same term as *Atkins*, the Court considered the proof necessary for sexual of-

fender civil commitment. 534 U.S. 407 (2002). Because "the science of psychiatry, which informs but does not control ultimate legal determinations, is an ever-advancing science, whose distinctions do not seek precisely to mirror those of the law," the Court declined to dictate particular criteria for determinations. *Id.* at 413. Instead, the Court accorded States "considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment." *Id.* Although this leeway led to a "less precise constitutional standard" than the parties sought, the Court did not remedy that imprecision by simply deferring legal determinations to the medical community. As the Court noted, the DSM-IV itself recognized the "'imperfect fit between the questions of ultimate concern to the law and the information contained in [the DSM's] clinical diagnosis.'" *Id.* at 413-14 (alterations in original) (quoting DSM-IV at xxxii-xxxiii). Therefore, as it did in *Atkins*, the Court in *Crane* elaborated "generally stated constitutional standards and objectives" rather than precise clinical criteria. *Id.* at 414.

In criminal law, the Court's approach is no different. In *Clark v. Arizona*, the Court recognized the substantial leeway States have in defining insanity. 548 U.S. 735, 749-53 (2006). Citing "significant differences" among State approaches to insanity, the Court found it "clear that no particular formulation has evolved into a baseline for due process, and that the insanity rule, like the conceptualization of criminal offenses, is substantially open to state choice." *Id.* at 749, 752. Leeway was appropriate, again, because of the imperfect fit between science and law. *See id.*; *see also Foucha v. Louisiana*, 504 U.S. 71, 96 (1992)

(Kennedy, J., dissenting) ("It is by now well established that insanity as defined by the criminal law has no direct analog in medicine or science."). The Court also cited the "flux and disagreement" among "medical definitions devised to justify treatment, like legal ones devised to excuse from conventional criminal responsibility." *Clark*, 548 U.S. at 752. A year later, in *Panetti*, the Court again refused to impose a nationwide definition of insanity, despite reaffirming the categorical bar against executing the insane. 551 U.S. at 960-61 ("[W]e do not attempt to set down a rule governing all competency determinations."); *see also supra* at 16.

Clark and *Panetti* exemplify the Court's longstanding reluctance to impose nationwide standards at the intersection of mental capacity and criminal law. *See also Powell v. Texas*, 392 U.S. 514, 536 (1968) (refusing to constitutionalize a concept of *mens rea*). This reluctance should be particularly pronounced in the *Atkins* context, which only highlights the imprecise fit between the fields of medicine and law: The medical definition of mental retardation is constantly evolving, and this area of the law prioritizes stability. The medical field focuses on treatment and assistive service—justifying expansive diagnostic categories—distinct from the law's interest in culpability, punishment, and deterrence. And medicine accommodates varied and conflicting opinions and wide-ranging disagreement about diagnoses, but the law needs settled rules for reasoned and consistent decision-making.

B. Continued Leeway for State Definitions of Mental Retardation Is Particularly Appropriate Because the Diagnostic Criteria Are Constantly Evolving.

The clinical definition of mental retardation—like the attendant labels—is in constant flux. While Florida agrees that the basic three-part framework for mental retardation has been constant—indeed, a version has been in Florida's statutes for 35 years—the diagnostic criteria for applying that definition have not. As the latest version of the DSM acknowledges, "[t]he science of mental disorders continues to evolve." APA, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 5 (5th ed. 2013) ["DSM-5"]; *accord* Douglas Mossman, M.D., Atkins v. Virginia: *A Psychiatric Can of Worms*, 33 N.M. L. REV. 255, 264 (2003) ("'Thoughtful clinicians' recognize the still-primitive nature of psychiatric diagnosis . . . ."). One need only compare various editions of the DSM or AAMR (now called the Association on Intellectual and Developmental Disabilities ("AAIDD")) Manuals to see that the definitions of mental retardation are not immune from change.[14] The AAIDD has published no

[14] Beyond the DSM and AAIDD, there are numerous organizations that publish their own criteria. The World Health Organization defines mental retardation as "a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, *i.e.* cognitive, language, motor, and social abilities." The WHO further classifies individuals by ranges of IQ scores, beginning with an "[a]pproximate IQ range of 50-69." *See* WHO, INT'L STATISTICAL CLASSIFICATION OF DISEASES AND RELATED

fewer than eleven editions of its definitional manual since 1908, and changes along the way have altered the class of persons meeting the definition. For example, the "adaptive behavior" component was added in 1959, decreasing the number of individuals who qualified. Robert L. Hayman, Jr., *Presumptions of Justice: Law, Politics, and the Mentally Retarded Paren*t, 103 HARV. L. REV. 1201, 1203 n.2 (1990). And notably, until 1973, the AAMR definition of mental retardation required an IQ score just one standard deviation below the mean. *Id*. That definition "overidentified people as having mental retardation, theoretically labeling 16% of the population." AAMR, MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 26 (10th ed. 2002) ["AAMR 10th"] (Today, the DSM-5 estimates the prevalence of mental retardation at one percent of the general population. DSM-5 at 38.)

Understandably seeking to minimize this constant change, Hall notes that the definitions' "basic parameters" have been long settled. Pet'r Br. 30. But his challenge is not about the basic parameters, and

---

HEALTH PROBLEMS, 10TH REVISION, *available at* http://apps.who.int/classifications/icd10/browse/2010/en#/F70-79 (last visited Jan. 24, 2014). The American Psychological Association separately defines mental retardation using a three-prong definition similar to that of the DSM and AAMR, though the age of onset prong is 22 and the intellectual functioning prong specifies a test score two standard deviations below the mean. *See* Jeffrey Usman, *Capital Punishment, Cultural Competency, and Litigating Intellectual Disability*, 42 U. MEM. L. REV. 855, 876-77 (2012).

there is no dispute that Florida follows these parameters. Hall's challenge is about the precise application of how these parameters are applied—an issue that is anything but settled.

1. *Intellectual Functioning*. Beginning around 1973, clinical diagnoses focused on IQ scores of 70 or below, based on a conclusion that this captured the range of individuals "so limited in their adaptive functioning that they require special services and protection." APA, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 37 (3d ed. 1980) ["DSM-III"]; *accord* AAMR 10th at 21 (summarizing prior definitions and noting that 7th edition, published in 1973, provided an IQ cutoff of two standard deviations below the mean or 70). Although the DSM-III observed that "any measurement is fallible" and that an "IQ score is generally thought to involve an error of measurement," it considered IQ paramount in the diagnosis: "[s]ignificantly subaverage intellectual functioning *is defined as* an IQ of 70 or below on an individually administered IQ test." DSM-III at 36 (emphasis added). Individuals with IQs above 70 had "borderline intellectual functioning," but not mental retardation. *Id.* at 40.

The DSM-IV, introduced in 1994, maintained the focus on an IQ of 70, but with less precision. It modified the criterion to "an IQ of *approximately* 70 or below," DSM-IV at 46 (emphasis added), though it still maintained that "[g]eneral intellectual functioning is defined by" a properly obtained IQ score and, like its predecessor, it still relied exclusively on IQ to categorize severity. *Id.* at 39, 40.

Around the same time, the AAMR introduced the Ninth Edition of its guide, with a definition requiring an IQ "score of approximately 70 *to 75* or below." AAMR 10th at 22 (summarizing standard adopted in 9th edition, published in 1992) (emphasis added). This updated definition "represent[ed] a radical departure from previous definitions," which "expanded the proportion of the general population that [would] be eligible for classification as having mental retardation." Donald L. MacMillan et al., *Conceptual and Psychometric Concerns About the 1992 AAMR Definition of Mental Retardation*, 98 AM. J. ON MENTAL RETARDATION 325, 325, 326 (1993); *see also* BENJAMIN JAMES SADOCK & VIRGINIA ALCOTT SADOCK, KAPLAN AND SADOCK'S SYNOPSIS OF PSYCHIATRY 1138 (10th ed. 2007) ("The AAMR promote[d] designating an IQ of 75, rather than 70, as the beginning level of the mild mental retardation range, thereby enabling many more persons to receive services as mentally retarded."). The DSM declined to follow the AAMR's approach in this regard, though the drafters of the DSM-IV adopted the AAMR's adaptive function domains. *Id.*

In the recently introduced DSM-5, there is still a reference to an IQ of 70, but there is substantially less focus on IQ altogether. The DSM-5 no longer uses IQ to classify severity levels, relying instead on descriptions of adaptive functioning. *See* DSM-5 at 33-36. More significantly, the DSM abandoned decades of defining intellectual functioning by IQ. *Compare* DSM-IV at 39 ("General intellectual functioning *is defined by the [IQ]* obtained by assessment . . . .") (emphasis added) *with* DSM-5 at 33 (requiring "[d]eficits in intellectual functions . . . confirmed by *both* clinical

assessment *and* individualized, standardized intelligence testing") (emphasis added). Thus, while it was long recognized that intellectual functioning was "quantifiable as an [IQ] score" precisely because it was "a phenomenon measured, and thus defined, by intelligence tests," James W. Ellis & Ruth A. Luckasson, *Mentally Retarded Criminal Defendants*, 53 GEO. WASH. L. REV. 414, 422 (1985), now the DSM-5 seeks to avoid "overemphasiz[ing]" them. APA, *Intellectual Disability Fact Sheet*, *available at* http://www.dsm5.org/Documents/Intellectual%20Disability%20Fact%20Sheet.pdf.

The latest edition of the AAMR (now the AAIDD) manual also offers expanded opportunities for diagnosing mental retardation, emphasizing that use of "approximately" in the IQ score criterion is not only to account for statistical error and "inherent" uncertainty, but also to allow for increased "clinical judgment." AAIDD, INTELLECTUAL DISABILITY: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 35 (11th ed. 2010) ["AAIDD 11th"]; *see also id.* ("The intent of this definition [is] not to specify a hard and fast cutoff point/score. . . .").

As these changes demonstrate, the DSM and AAIDD are trending away from the objectivity associated with reliance on IQ tests. By decreasing the significance of these objective data and increasing reliance on amorphous "clinical judgment," the definitions ultimately change the category of persons qualifying for a mental retardation diagnosis. As the chair of the task force that developed the DSM-IV noted in reviewing the DSM-5, "[r]emoving the IQ requirement for [mental retardation] reduces the

reliability and precision of diagnosis and will have forensic implications." Allen Frances, *DSM 5 Writing Mistakes Will Cause Great Confusion*, Psychology Today (June 11, 2013), *available at* http://www.psychologytoday.com/blog/saving-normal/201306/dsm-5-writing-mistakes-will-cause-great-confusion.

2. *Adaptive functioning*. Since its introduction in 1959, the adaptive functioning prong has likewise seen constant change—not only in its evaluation but also in its use. As noted above, the DSM-5 now uses adaptive functioning as the means for differentiating among mental-retardation severity levels—after relying exclusively on IQ for decades. The AAIDD defines the prong as "significant limitations . . . in adaptive behavior as expressed in conceptual, social, and practical adaptive skills." AAIDD 11th at 1. The DSM-5 offers this explanation:

> Deficits in adaptive functioning that result in failure to meet developmental and sociocultural 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.

DSM-5 at 33. But there have been variations along the way. "In 1992 the concept of global adaptive behavior was replaced by 10 broad adaptive skill areas and the requirement that 2 or more of the 10 skills be

documented as deficient." AAMR 10th at 25. With some overlap, the Text Revision to the DSM-IV, published in 2000, required a showing of limitations in two of *eleven* areas. APA, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 41 (4th ed. Text Revision 2000). The AAMR then reversed course and began measuring adaptive deficits in three skill areas instead of ten, and requiring a showing of limitation in only one of those three. AAMR 10th at 73-74. The DSM changed, too—now advancing more general criteria. *Compare* DSM-IV-TR at 41 (requiring "significant limitations in adaptive functioning" in at least two of eleven specific skill areas) *with* DSM-5 at 37 (referring to failures to "meet[] community standards of personal independence and social responsibility" across three domains). At bottom, "the concept" of adaptive functioning "is still being elaborated by experts in the field." Richard J. Bonnie, *The American Psychiatric Association's Resource Document on Mental Retardation and Capital Sentencing: Implementing* Atkins v. Virginia, 28 MENTAL & PHYSICAL DISABILITY L. REP. 11, 12 (2004); *cf. also id.* ("[S]tandardized instruments are in a continuing process of development.").

3. *Age of Onset*. Even the simplest, final criterion—age of onset—is changing. For decades, the DSM required that the symptoms appear before age 18. *See* DSM-III at 37 ("When the clinical picture develops for the first time after the age of 18, the syndrome is a Dementia, not Mental Retardation . . . ."). But the DSM-5 abandons this bright-line age limit, now requiring onset "during the developmental period." DSM-5 at 33. (The AAIDD still maintains an objective age limit. *See* AAIDD 11th at 1.) This latest change—

replacing a bright-line rule with a vague criterion—not only makes mental retardation diagnoses still less precise but also further demonstrates the inability of the psychiatric community to settle on a universal definition of mental retardation.

* * *

When it comes to diagnostic criteria for mental retardation, the only constant is change. In light of the "flux and disagreement," the risks of constitutionalizing changing clinical criteria are obvious. In the context of evolving science, "courts should pay particular deference to reasonable legislative judgments." *Jones v. United States*, 463 U.S. 354, 364 n.13 (1983); *cf. also Baze v. Rees*, 553 U.S. 35, 51 (2008) (plurality opinion) (standard for execution procedures "would threaten to transform courts into boards of inquiry charged with determining 'best practices' for executions, with each ruling supplanted by another round of litigation touting a new and improved methodology . . . [and] would embroil the courts in ongoing scientific controversies beyond their expertise, and would substantially intrude on the role of state legislatures in implementing their execution procedures"). If the Eighth Amendment required courts to apply consensus clinical definitions, the law would change every time the definitions did, making the *Atkins* analysis all the more difficult for courts applying it. But courts would first have the additional burden of determining what the current "consensus" actually is—a task complicated by the competing authorities' unresolved disagreements.

C. States Should Not Be Forced To Agree With Authorities That Themselves Cannot Agree.

It should be no surprise that "statutory definitions of mental retardation are not identical," *Atkins*, 536 U.S. at 317 n.22, because even the prevailing authorities cannot agree on a single definition. Despite faulting Florida for not relying on "the universally accepted clinical definition," Pet'r Br. 3, Hall never identifies this definition, because it does not exist. *See Lynch v. State*, 951 So. 2d 549, 557 (Miss. 2007) (Randolph, J., specially concurring) ("The difficulty in performing this arduous task is accentuated by disagreements among mental health practitioners on the definition of mental retardation."); *cf. Ake v. Oklahoma*, 470 U.S. 68, 81 (1985) ("Psychiatry is not . . . an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness [and] on the appropriate diagnosis to be attached to given behavior and symptoms . . . ."); *cf. also Atkins*, 536 U.S at 308 n.3 (describing the DSM's definition only as "similar" to the AAMR's).

Although Petitioner asserts that differences among competing diagnostic guides do "not differ substantively in any meaningful way," Pet'r Br. 29, one can assume that the AAIDD and APA would not insist on maintaining meaningless differences. Yet it remains unavoidable that the DSM and the AAIDD (and the WHO or the American Psychological Association, *see supra* n.14) *do* maintain their differences and cannot agree on a single definition. *See also* Br. of APA et al. at 8 n.6 (noting that the definitions in the AAIDD and DSM-5 (published by the APA) "differ in

some particulars"); Br. of AAIDD et al. at 9 (acknowledging "minor variations" in the definitions).

Regardless, the differences are not meaningless. For example, the DSM and AAIDD use different terms to describe how adaptive functioning should be diagnosed, Bonnie, *supra*, at 12, and they have yet to reach consensus, *compare id.* ("It should be noted that the AAMR definition reflects the most recent scientific understanding of the concept of adaptive behavior."), *with* MacMillan, *supra*, at 325 (calling the AAMR adaptive skills guidelines "too unreliable for decision-making"); Gilbert S. Macvaugh III & Mark D. Cunningham, Atkins v. Virginia: *Implications and Recommendations for Forensic Practice*, 37 J. PSY. & L. 131, 138-39 (2009) (noting that AAIDD adaptive functioning definition "has been criticized for lacking theoretical grounding and empirical research support" and that some "have questioned whether a new definition, at least in terms of measuring deficits in adaptive behavior, is needed for the purpose of forensic cases").

The AAIDD and the APA cannot even agree on the age-of-onset requirement. As explained above, the DSM long defined the "age of onset" requirement to require symptoms to appear before age 18. The DSM-5 now removes the objective age limit, favoring the nebulous term "developmental period." DSM-5 at 33. The AAIDD's latest definition, though, rejects the change and maintains a strict limit of 18, in part because "extending to the age of 21 . . . would include individuals with other cognitive disabilities." AAIDD 11th at 28; *but see supra* n.14 (American Psychological Association's definition uses age 22).

This only acknowledges the obvious: different criteria yield different outcomes. Those labeled "mentally retarded" under one definition might not be under another definition. *See generally* DSM-IV at 44 (noting estimate of prevalence of mental retardation in population but acknowledging estimates vary depending on definition used in study). This is true whether applying non-identical *clinical* definitions or non-identical *statutory* definitions.

Although the Court should not constitutionalize a single definition or set of clinical criteria in any event, it would be particularly inappropriate to do so when there is no single clinical definition on which the profession can agree. *Cf. Clark v. Arizona*, 548 U.S. 735, 753 (2006) ("There being such fodder for reasonable debate about what the cognate legal and medical tests should be, due process imposes no single canonical formulation of legal insanity."). Nor is it an answer to say that notwithstanding many differences, the AAIDD and APA agree on using a standard error of measurement ("SEM"). Hall bases his challenge on the fact that Florida (and other states) deviate from the clinical criteria. *See* Pet'r Br. 33 ("[B]ecause Florida's definition of mental retardation excludes persons who meet the clinical definition of the disability[, it] violates . . . *Atkins* . . . ."), and he offers no principle to confine any ruling to the SEM. The ruling he seeks would effectively constitutionalize all of the clinical criteria. Under his rule, any State deviating from the clinical criteria, whether related to the SEM or not, would face new legal claims.

D. A Constitutional Rule Requiring Adherence to Prevailing Diagnostic Criteria Promotes Detrimental Incentives in the Medical Community.

One point on which many professional organizations *do* agree is that an *Atkins*-type exemption should extend beyond the mentally retarded. The American Bar Association, the APA (publisher of the DSM), the American Psychological Association, and others, officially propose defining the class of persons exempted under *Atkins* to include those with dementia and other brain injury, which this proposal asserts are "very similar to mental retardation in their impact on intellectual and adaptive functioning." *Recommendation and Report on the Death Penalty and Persons with Mental Disabilities*, 30 MENTAL & PHYSICAL DISABILITY L. REP. 668, 669 (2006). Although the issue of expanding *Atkins* beyond the mentally retarded is not presented here, these groups' advocacy on this point demonstrates another problem with yielding *Atkins* determinations to them.

One need not disparage the APA, AAIDD, or similar groups, to recognize that their objectives do not include preserving the death penalty. Florida, on the other hand, has important penological goals of punishing criminals and deterring future crimes—goals that medical organizations do not necessarily share. Nor do these organizations necessarily share the State's interest in enforcing all sentences to the extent constitutionally permitted. Instead, "[s]ome organizations to which many mental retardation professionals belong are zealous advocates for the abolishment of the death penalty, whether administered to retarded,

dull, average, bright or genius individuals." *Lynch v. State*, 951 So. 2d 549, 558 (Miss. 2007) (Randolph, J., specially concurring).[15]

There is also evidence suggesting that these organizations—and the diagnostic guides they produce—are not immune from political considerations. "Although psychiatric diagnoses are often revised to reflect new understandings, scientific breakthroughs, or availability of new treatment approaches, sometimes social and political developments play a role." Mossman, *supra*, at 265-66. Lamentably, some have found that "[s]cience is often subordinated to social and political influences in the development and use of the diagnostic categories contained in DSM." HERB KUTCHINS & STUART A. KIRK, MAKING US CRAZY: DSM: THE PSYCHIATRIC BIBLE AND THE CREATION OF MENTAL DISORDERS 16 (1997); *see also* Mossman, *supra*, at 265 & n.105. Further, since the new diagnostic criteria are not tied to research in the

[15] For example, the AAIDD notes it "has always advocated against the death penalty." *See* AAIDD, *Frequently Asked Questions on Intellectual Disability and the AAIDD Definition* at 5, http://aaidd.org/docs/default-source/sis-docs/aaiddfaqonid_template.pdf?sfvrsn=2. Similarly, the American Psychological Association published a resolution challenging the validity of capital punishment's penological goals. Am. Psychological Ass'n, *The Death Penalty in the United States*, *available at* http://www.apa.org/about/policy/death-penalty.aspx (last visited Jan. 24, 2014).

field, "the claims of science-at-work are difficult to verify or dispute." KUTCHINS & KIRK, *supra*, at 38.[16]

Notably, the DSM's and AAIDD's decreased reliance on objective criteria, including IQ scores, corresponds with calls for increased judicial reliance on the same associations' evolving clinical criteria. In fact, both the DSM and the AAIDD manuals appear to embrace the prospect of increased influence in the courts. While the DSM-IV had cautioned that "the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes" of a mental disorder or disease, DSM-IV at xxiii, the DSM-5, states that while its purpose is "primarily" to assist clinicians, it also serves "as a reference for the courts and attorneys in assessing the forensic consequences of medical disorders," DSM-5 at 25. The AAIDD even cited *Atkins* in promoting its 10th edition, calling the manual "a timely and critical resource to the states as they strive to come up with a current and fuller definition of mental retardation.'" Mossman, *supra*, at 266 (quoting AAMR Home Page, http://www.aamr.org (no longer available online)).

---

[16] The British Psychological Society—"the learned and professional body for psychologists in the United Kingdom," with some 50,000 members—prepared a formal response to the DSM-5, criticizing the DSM-5's reliance on "social norms" and "subjective judgments." The British Psychological Society, *Response to the Am. Psychiatric Ass'n*: DSM-5 Development (June 2011), *available at* http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf.

If the Court determines *Atkins* commands strict adherence to clinical criteria—and whatever subsequent changes they next embrace—the professionals responsible for publishing those criteria would have unavoidable incentives to adopt even more expansive definitions of mental retardation and place even less emphasis on any objective factors, all to the detriment of the law, medical treatment, or both.

None of this is to say that the Court should ignore the APA, the AAIDD, or their proffered diagnostic criteria. These groups undoubtedly contribute to the overall understanding of mental health issues generally and mental retardation specifically. *Cf. Panetti*, 551 U.S. at 962 ("The conclusions of physicians, psychiatrists, and other experts in the field will bear upon the proper analysis."). Legislatures can look to these groups and their opinions when shaping policy determinations, and courts can look to them for information bearing on constitutional determinations. But "overreliance" on the DSM or others "is dangerous." Douglas A. Hass, *Could the American Psychiatric Association Cause You Headaches? The Dangerous Interaction Between the DSM-5 and Employment Law*, 44 LOY. U. CHI. L.J. 683, 693 (2013); *see also id*. (lamenting "the seemingly blind obeisance in legal circles for the DSM result[ing] in practitioners, courts, and judges . . . treating a DSM diagnosis as a proven fact with legal consequences, rather than the hypothesis that it often represents"). As in *Atkins*, the Court can consider the information these groups offer, but the ultimate answer resides elsewhere.

III. FLORIDA'S STANDARD IS AN APPROPRIATE MEANS OF ENFORCING *ATKINS*.

State leeway to enforce *Atkins*'s mandate is not limitless, of course. States cannot evade *Atkins* by crafting definitions of mental retardation that attempt to undo the rule that *Atkins* announced. *Cf.* Pet'r Br. 31 (arguing State could not evade *Atkins* by implementing an IQ cutoff of 50). But far from seeking to evade *Atkins*, Florida's statute—which predated *Atkins*—sought what *Atkins* sought: a death-penalty exemption for those whose cognitive and behavioral deficiencies would make death an inappropriate punishment. And Florida's statute did so in a manner that remains fully consistent with the Eighth Amendment.

A. Florida's Definition Generally Conforms to Clinical Definitions, and Any Deviations Are Justified.

No one disputes that Florida's definition incorporates the same three fundamental concepts that Hall embraces—and that the Court highlighted in *Atkins*. Florida requires a showing of "significantly subaverage general intellectual functioning," and "deficits in adaptive behavior," which manifest before age 18. FLA. STAT. § 921.137(1); *compare Atkins*, 536 U.S. at 318 (noting how clinical definitions require "subaverage intellectual functioning," "significant limitations in adaptive skills," and "manifest[ation] before age 18"); *cf. In re Turner*, 637 F.3d 1200, 1205 (11th Cir. 2011) (per curiam) (finding Florida's definition "substantially identical to that of . . . the clinical definitions in *Atkins*."). And Florida law, like the clinical definitions, requires a finding *on all three prongs*.

See Cherry v. State, 959 So. 2d 702, 711 (Fla. 2007); *see also* DSM-5 at 33 (stating that a patient "must" show all three prongs to satisfy the standard).

Next, Florida did not manufacture its IQ threshold out of thin air. Florida adopted its statutory prohibition after years of deliberation, including testimony from prosecutors, defense attorneys, and community groups, and it incorporated a definition, from a different section of Florida's statutes, that had worked for over twenty years. *See* Senate Staff Analysis at 11. Moreover, a 70 IQ has long been viewed as an appropriate upper limit for mental retardation. As described above, guides have long referred to 70 as an appropriate cutoff, *see supra* Part II.B, and no fewer than nine states referenced 70 in their statutes at the time of *Atkins*, *see supra* n.12. In addition, this Court referenced 70 as a ceiling on several occasions. *E.g.*, *Penry v. Lynaugh*, 492 U.S. 302, 308 n.1 (1989) ("To be classified as mentally retarded, a person generally must have an IQ of 70 or below."); *see also Atkins*, 536 U.S. at 308 n.3; *id.* at 316; *Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 442 n.9 (1985).

Although States can choose another ceiling, a higher threshold would substantially expand eligibility for diagnosis. "Twice the proportion of people have scores at or below 75 (5.48 percent) than have scores at or below 70 (2.68 percent)." DANIEL J. RECHSLY, ET AL., NAT'L RESEARCH COUNCIL, MENTAL RETARDATION: DETERMINING ELIGIBILITY FOR SOCIAL SECURITY BENEFITS 210-11 (2002); *accord* MacMillan, *supra*, at 327; *see also id.* ("More people fall in the IQ interval 71 to 75 (i.e., 2.80%) than in the entire range previously associated with mental retardation (IQ 70 and below,

i.e., 2.68%). . . ."). In *Atkins*, the Court cited an estimate of between 1 and 3 percent for the population with an IQ in the range of 70 and 75 or lower, 536 U.S. at 309 n.5; requiring an IQ higher than 70 would sweep in far more individuals than the *Atkins* Court anticipated.

Although not entirely clear, Hall does not appear to quarrel with the use of 70 generally. The thrust of his argument is that the Florida definition improperly ignores the SEM and therefore disallows a finding of mental retardation when a defendant's IQ falls above 70, but within approximately five points of 70. This is effectively identical to requiring an IQ threshold of 75, which no State used at the time of *Atkins*, and which would greatly expand the population covered under *Atkins*.

Florida, like other states, has an important interest in ensuring that the constitutionally allowed judgments of its courts and juries are enforced, and it is entitled to limit the coverage of section 921.137 and rule 3.203 to the scope of the *Atkins* consensus. Florida also recognized that the risk of over-diagnosis of mental retardation is particularly pronounced in this setting as capital offenders have every incentive to secure such a diagnosis and the risk of malingering is very real. *See Atkins*, 536 U.S. at 353-54 (Scalia, J., dissenting). Incorporating a bright-line rule and utilizing objective evidence of intellectual deficiency is a valid means of countering this possibility. Further, Florida's omission of an SEM also promotes administrability and consistency, reducing the risk of arbitrary application of the standard. *Cf. Gregg v.*

Georgia, 428 U.S. 153, 188-89 (1976) (joint opinion of Stewart, Powell, and Stevens, JJ.).

The fact that consideration of the SEM is accepted in determining eligibility for services or in the educational setting is of no moment. Mental-retardation evaluations in the *Atkins* context differ from evaluations in other contexts. *See Chester v. Thaler*, 666 F.3d 340, 345-46 (5th Cir. 2011) ("[T]he AAMR definition was designed for the purpose of providing social services, not for the purposes of determining whether a person was 'so impaired as to fall within the range of mentally retarded offenders about whom there is national consensus.'") (citing *Ex parte Briseno*, 135 S.W.3d 1 (Tex. Crim. App. 2004)), *cert. denied*, 133 S. Ct. 525 (2012). In the medical context, for example, an error measurement is consistent with the desirability of providing treatment to a broader group of people. *See* MacMillan, *supra*, at 326; *cf.* AAIDD 11th at 7 ("Labeling someone with the term [mental retardation] should lead to a benefit, such as a profile of needed support.").[17] In the *Atkins* context,

[17] Hall argues that Florida does not consistently apply its statutory definition in all situations, *see* Pet'r Br. 47, citing a vocational education regulation that expressly relies on the DSM, *see* FLA. ADMIN. CODE. ANN. R. 6A-25.005 (2014). The fact that Florida uses different standards for educational and criminal purposes is unsurprising given the differing considerations in each area. Regardless, Florida has used an IQ cutoff of 70 for other purposes. *See, e.g., id.* R. 65G-4.017(3)(a) (referring to single full-scale IQ score of 70 as grounds for reliance on single test or sub-test in determining eligibility for services); *accord Cherry v. State*, 959 So. 2d 702, 712 (Fla. 2007); *see also* FLA. STAT.

though, error measurements do not serve those same purposes, as Hall's case shows.

First, like most defendants pursuing *Atkins* claims, Hall had multiple test scores over many years. "The pattern of test scores is more important than the score on any given test." ALLEN FRANCES, ESSENTIALS OF PSYCHIATRIC DIAGNOSIS: RESPONDING TO THE CHALLENGE OF DSM-5 at 30 (2013). And "[w]hen there is marked variability, the higher scores are likely to be the more indicative, since there are many reasons why a given score might underestimate a person's intelligence, but no reason why scores should overestimate it." *Id.* at 31. Florida's Rule allows for multiple evaluations, and if Hall believed a statistical error rate prevented any of his tests from reflecting his true score, he could have sought still more testing.

Moreover, accepting an error measurement is inconsistent with another aspect of the *Atkins* inquiry—the burden of proof. Florida requires that a defendant establish *Atkins* eligibility by clear and convincing evidence, a burden Hall does not challenge. A defendant whose best showing on the intellectual functioning prong is that his test score *above* 70 could conceivably (with application of a broad error range) show an IQ *below* 70, has not proven his disability by clear and convincing evidence.[18]

---

§ 393.063; *State v. Kinner*, 398 So. 2d 1360 (Fla. 1981) (civil commitment).

[18] In this case, Hall claims his recent IQ score of 72 "is more appropriately expressed in terms of a 95% probability that his true score lies between 68 and 76." Pet'r Br. 40.

Although Florida's standard may not precisely mirror the DSM or the AAMR in all respects, it uses the same "essential criteria," recognized in *Atkins*, Pet'r Br. 34, and it "generally conform[s] to the clinical definitions," *Atkins*, 536 U.S. at 317 n.22. It is well-suited to the legal inquiry that an *Atkins* claim requires, it is consistent with Florida's interest in enforcing constitutional judgments, and it does not violate the Eighth Amendment.

Finally, Florida's standard works in conjunction with *Penry*. *See* Senate Staff Analysis at 4, 11. In proving mitigating factors, defendants can introduce evidence that they satisfy some non-statutory definition of mental retardation, under whatever definition the defense expert employs. *Cf. Wood v. Allen*, 558 U.S. 290, 307 n.3 (2010) (Stevens, J., dissenting) ("Although Wood does not fall within the class of individuals we identified in *Atkins* . . . the reality that the defendant was borderline mentally retarded, might well influence the jury's appraisal of his moral culpability.") (marks, alterations, and citation omitted). Consistent with *Atkins*, Florida's rule operates as a backstop to ensure that those *Atkins* protects will not face the death penalty even if aggravating factors outweigh such mitigating evidence.

Even if there were such a probability, that would be insufficient to prove by clear and convincing evidence that Hall's true IQ were 68 or 69 rather than 71-76. *Cf. Clark*, 457 F.3d at 446 ("The court was not required to find [defendant] to be mentally retarded merely because the low end of [his] confidence band was below 70, just as it would not be required to find that [he] could be executed on the basis that the high end of this band fell above 70.").

B. There Is No National Consensus Regarding the Use of Error Measurements, and Florida's Approach Is Consistent with Other States'.

While Hall suggests Florida's approach is an outlier, he makes no serious effort to identify a consensus against a framework that excludes the use of clinical diagnostic criteria like the SEM within the meaning of *Atkins* or *Roper*. *Cf. Stanford v. Kentucky*, 492 U.S. 361, 373 (1989) (noting the "heavy burden" a petitioner bears to establish a national consensus) (quoting *Gregg*, 428 U.S. at 175). There is no such consensus. As Justice Pariente found, ten states that employ the death penalty have a rule that does not apply the SEM, including Florida. *See* JA133 (collecting statutes). In addition, a number of state courts to consider the SEM have rejected its use. *See Smith v. State*, 71 So. 3d 12, 20 (Ala. Crim. App. 2008) ("If this Court were to adopt a 'margin of error' it would, in essence, be expanding the definition of mentally retarded . . . ."); *Pizzuto v. State*, 202 P.3d 642, 651 (Idaho 2008) (noting that "the legislature did not require that the IQ score be within five points of 70 or below. It required that it be 70 or below" and stating that if error measurement were considered, inference that above-70 IQ score showed defendant's IQ was actually further above cut-off was just as reasonable as inference that it was below); *Bowling v. Commonwealth*, 163 S.W.3d 361, 375 (Ky. 2005) ("The General Assembly chose not to expand the mental retardation ceiling by requiring consideration of [error measurement], but instead, like most other states that quantify the definition, chose a bright-line cutoff ceiling of an IQ of 70, a generally recognized level at which persons are con-

sidered mentally retarded."); *see also State v. Backus*, 287 P.3d 894, 904-05 (Kan. 2012); *Johnson v. Commonwealth*, 591 S.E.2d 47, 59 (Va. 2004), *rev'd sub nom. on other grounds Johnson v. Virginia*, 544 U.S. 901 (2005); *Rankin v. State*, 948 S.W.2d 397, 404 (Ark. 1997). Some States choose otherwise, but "there is no clear consensus among the states regarding the use of the SEM." JA134 (Pariente, J., concurring).

More broadly—and more importantly—there is no consensus among the States to embrace the full range of clinical criteria. States differ as to IQ scores, adaptive functioning, and age of onset, meaning that a defendant conceivably could satisfy one State's definition but not another's. This possibility was apparent before *Atkins*, *see* JA134 (Pariente, J., concurring) (noting that Hall might meet other States' definitions but that "mental retardation, unlike age, is not a fixed, objective test, and therefore these variations appear to have been contemplated [in] *Atkins*"), and it presents no constitutional problem. In fact, it is consistent with other *Atkins* rules and procedures that necessarily might yield different results in different States. States, for example, differ on the burdens of proof for *Atkins* claims, *compare* OKLA. STAT. tit. 21 § 701.10b(F) (preponderance of evidence), *with* ARIZ. REV. STAT. ANN. § 13-753(G) (clear and convincing evidence); *and* GA. CODE ANN. § 17-7-131(c)(3) (beyond reasonable doubt), and on whether a judge or jury makes the determination, *compare* VA. CODE ANN. § 19.2-264.3:1.1 (2013) (jury) *with* IDAHO CODE ANN. § 19-2515A(3) (judge); *see also Schriro v. Smith*, 546 U.S. 6, 6-7 (2005) (per curiam). Nevertheless, none of these legislative choices violates *Atkins*; they were exactly what the Court anticipated when it "le[ft] to the

States the task of developing appropriate ways to enforce the constitutional restriction." 536 U.S. at 317.

C. Hall's Proposed Approach Would Undermine Important State Interests That Depend on Objective, Settled Measures.

The argument Hall advances, if accepted, would undermine important State interests. As noted above, Florida's disallowance of an SEM serves a number of important justifications, each of which Hall's rule would directly undermine. *See supra* Part III.A. But Hall's approach, under which States violate *Atkins* unless they exempt anyone who satisfies modern clinical diagnostic criteria, goes further. Accordingly, Hall's approach would undermine an even greater range of interests.

First, Florida has an interest in finality. If *Atkins*'s scope constitutionally incorporated current clinical criteria, then every update would result in new *Atkins* challenges. Defendants who had failed under earlier definitions would insist they could succeed under the new ones. And by the time one round of hearings and appeals ended, new diagnostic criteria would be ready to start the process again. Future litigation would be endless. *Cf. Baze v. Rees*, 553 U.S. 35, 51, 61 (2008) (plurality opinion) (noting States' legitimate interest in carrying out sentence in a timely manner and citing risk of endless litigation from proposed standard for evaluating execution methods).

Second, Hall's rule would undermine Florida's interest in objective decision-making. Establishing a specific threshold a defendant must satisfy before injecting the more subjective considerations relating to

adaptive functioning provides certainty and minimizes false claims of retardation. Hall's position—and the uncertainty it invites—would maximize those false claims. No IQ score would ever definitively end the inquiry (Hall and his amici conspicuously decline to suggest any true cutoff score) and States would be forced to consider the more subjective adaptive functioning in every case. *See* Br. of APA et al. at 14-17; Br. of AAIDD et al. at 12-14. Hall and his amici fault Florida's standard because, if a defendant fails to establish an IQ under 70, the rule precludes consideration of adaptive functioning. *See* Pet'r Br. 48-49, Br. of AAIDD et al. at 20-22. But this is an argument against any conjunctive standard, including the ones employed by most other states in the *Atkins* consensus as well as the clinical definitions themselves. If a defendant fails to satisfy the intellectual functioning prong, whether it is set at an IQ of 70 or 80—and whether it incorporates the SEM or not—that ends the inquiry, because the Defendant will not satisfy all three prongs as required. The logic of Hall's preferred approach would allow a mental retardation diagnosis at *any* IQ, essentially eviscerating the longstanding intellectual functioning prong by collapsing it into the less objective adaptive functioning prong.

Similarly, Hall's argument that an IQ of 70 is clinically indistinguishable from an IQ of 71, Pet'r Br. 34, invites even greater uncertainty. By that logic, a 75 is indistinguishable from a 76, and so on. Wherever the line is, the clinical definition that "separates persons who receive this diagnosis from individuals whose mental capacities are only well below average is a changing and arbitrary one." Mossman, *supra*, at

265 (note omitted). As a result, "judges, or juries, will often have a hard time deciding on which side of the arbitrary line between mentally retarded and merely 'dull' a defendant falls." *Id.* at 270 (note omitted). But that does not mean there is no line. Whatever the standard—in this context or others—there will be those who fall just above and just below it. Just as someone who kills the day after his eighteenth birthday misses the exemption afforded by *Roper*, *see* 543 U.S. at 574, someone with below average intelligence but not mental retardation misses *Atkins*'s bar.

The answer to the difficulty in diagnosing mental retardation is not to require States to further blur the line or to eliminate it entirely. The better approach is the one suggested by *Atkins* itself. The *Atkins* Court relied on two foundations, a general national consensus, *see supra* Part I.B, and the Court's "own judgment" brought to bear on the question, *supra* Part I.C. *Atkins* therefore requires that courts defer to a State's determination unless its definition falls well outside of the consensus described in *Atkins* or undermines the Court's independent judgment as to the category of persons protected.

Florida's framework satisfies such a standard. First, Florida's definition is unquestionably within *Atkins*'s consensus. *See supra* Part I.B. Second, nothing in Hall's brief shows that Florida's requiring an IQ of 70 rather than 75 undermines the Court's judgment by excluding those who are incapable of premeditation, are unable to be deterred, or are at any greater risk of wrongful execution. *See generally Atkins*, 536 U.S. 317-21; *cf. Panetti*, 551 U.S. at 958-59 (rejecting circuit court's standard for determining

competency because it excluded individuals with characteristics described in *Ford*). Hall has not even attempted such a showing, relying solely on a mismatch between Florida's standard and certain clinical criteria. His case presents no basis for overturning the legislative judgment of Florida and other States.

IV. HALL IS NOT MENTALLY RETARDED.

Finally, although Hall spends much of his brief purportedly establishing his mental retardation, the full picture tells a different story. After considering voluminous testimony and evidence, the trial court made extensive factual findings and rejected Hall's arguments on every prong.

A. The Facts of the Crime Are Flatly Inconsistent with Hall's Belated Claims of Mental Retardation.

In denying Hall's *Atkins* claim, the trial judge placed great weight on the facts of the crimes. And rightfully so. There is no dispute that Karol Hurst's kidnapping and murder was part of a multi-step plan to steal her car, rob a convenience store, avoid use of Ruffin's car in order to evade capture, and avoid leaving witnesses. JA34, 62, 69. Hall's crimes were not the basis of impulse or misunderstanding but followed a premeditated plan. *Cf. Atkins*, 536 U.S. at 318; *see also id.* at 319-20 (noting that the "cold calculus" that precedes premeditated, deliberated murder is "at the opposite end of the spectrum from behavior of mentally retarded offenders"). Indeed, the resentencing court found that Hall qualified for Florida's "cold, calculated, and premeditated" aggravating factor. JA33-34. Even the shooting of Deputy Coburn was based on

Hall's logical, thought-out conclusion that if Coburn discovered that Hall, a convicted felon on parole, had a gun, Hall would return to prison. *See* 1993 ROA v.9 R.1509-10. This displays logical reasoning, *cf. Atkins*, 536 U.S. at 318, as well as an ability to process information regarding a potential penalty "and, as a result, control [his] conduct," *cf. id.* at 320. Hall's efforts to cover up the crimes and evade capture likewise demonstrate planning, reasoning, and an ability to be deterred. *Cf. Chester*, 666 F.3d at 350 ("[W]e wish to note a few striking facts from the record that highlight the deficiency of petitioner's claim [regarding] deficiencies in adaptive behavior[:] Petitioner carefully cased the house of his victims, located the telephone box, cut the telephone wires, entered through an unlocked door (presumably to avoid the noise that would accompany breaking in), disguised himself in a ski mask, and raped/sodomized the two women inside using all the precautions one might expect to see from a clever criminal. After murdering the girls' uncle, Petitioner fired his gun into the locked doors of the victim's car, apparently reasoning that shooting a lock would break it and cause it to fail. This was hardly the work of a person with diminished mental capacity; it was problem-solving in response to a crisis.").

The facts of the crime directly undermine Hall's arguments regarding adaptive functioning. Hall relies on the testimony of experts who examined him a decade or more after the crime. *See* Pet'r Br. 51-52. But as Judge Tombrink noted in 1991, the testimony was such "professional overkill" that if "believed and taken to its logical conclusion, [Hall] is practically a vegetable." JA42. As Judge Tombrink concluded—and as

Hall's own expert, Dr. Krop, appears to have believed, *see supra* n.7—this evidence cannot square with the facts of the crime.[19]

B. The Totality of Hall's Medical Evidence Fails To Show That His Mental State Is Attributable to Mental Retardation.

Setting aside the facts of Hall's crimes, the medical evidence demonstrates that Hall is not mentally retarded, even under the clinical definitions he proposes.

The full record of Hall's intelligence testing demonstrates that, until just before his resentencing, Hall consistently tested above the consensus range for mental retardation. *See supra* at 8. He achieved IQ scores of 76, 79, 80, 60, 73, 74, 69, 71, and 72, scoring his highest in the years surrounding the murder and scoring outside the range until just before he made his first claim of mental retardation. At every point before 1988, including on a test administered less than a year after the murders, Hall consistently scored above

---

[19] Hall has presented his own narrative of the events of the crime, sponsoring testimony at his resentencing of a supposed confession by Ruffin. Ruffin reportedly admitted that he alone shot Hurst. 1993 ROA v.9 R.1605-07. However, Ruffin also reportedly said that before the shooting "Freddie told him, you got to prove yourself [to] be a man," and that Hall handed Ruffin the gun, which Hall had stolen, that Ruffin used to kill Hurst. *Id.* v.11 R.1874-75. Rather than demonstrating that Hall was a "follower[] rather than [a] leader[]," *Atkins*, 536 U.S. at 318, this shows precisely the opposite. Finally, even in this version, Hall fired the shot that killed Deputy Coburn. *Id.* v.9 R.1611.

the consensus IQ threshold *with or without the SEM*.[20]

Hall now tries to obscure these facts. First, Hall claims that the Court should disregard his above-range IQ scores from 1968 and 1979 because he achieved these scores on Beta and Kent tests, which Hall claims are unreliable and not acceptable under Florida law. Pet'r Br. 12 n.5. Aside from incorrectly describing Florida law,[21] this argument ignores the fact that Hall has consistently relied on his Beta Test performance *from 1988*, including in briefing to this Court, when that evidence has suited him. *See, e.g.*, Pet. for Cert. at 4 (quoting JA73 (Barkett, J., dissenting) ("The testimony reflects that Hall has an IQ of 60 . . . .")); *see also* Pet. for Cert., 01-6939, at 1 ("Freddie Lee Hall is mentally retarded with an IQ of 60."). Moreover, the argument ignores the fact that the 1968 and 1979 scores are consistent with Hall's 1986 performance on the Wechsler Adult Intelligence Scale, which Hall describes as "the 'gold standard' in IQ testing." Pet'r Br. 12 n.5.[22] The record of Hall's

---

[20] Hall makes much of the fact that school teachers, at various points, wrote that he was slow or mentally retarded. *See, e.g.*, Pet'r Br. 7, 50. There is no record evidence that any of his teachers were qualified to make such a diagnosis. Regardless, the IQ threshold until 1973 was only one standard deviation from the mean—a far more lenient standard than even Hall advocates here. *See supra* Part II.B.

[21] *See* Fla. R. Crim. P. 3.203(b) (specifying that court is to consider "all other evidence" of mental retardation).

[22] Hall attempts to downplay *that* performance by noting it was "administered by a graduate student." Pet'r Br.

intelligence testing is simply inconsistent with mental retardation.

Hall fares even worse on the other two prongs. As Judge Tombrink held, the adaptive functioning prong required that Hall make a showing of deficient adaptive functioning concurrent with his intelligence testing—not evidence from thirty years earlier. Hall makes no challenge to this ruling and, as his trial counsel and expert acknowledged, they prepared no evidence at all of concurrent adaptive functioning.[23] JA111; *see also supra* n.10. As to the third prong, requiring onset of mental retardation before age 18, the court held that while Hall presented evidence of adap-

---

18 & n.10; *see also id.* at 12. Again, Hall's argument is at odds with his earlier positions: Hall did not hesitate to rely on the conclusions of the "graduate student," Marilyn Feldman, when he viewed it to advance his cause. *See, e.g.*, JA19. Regardless, Hall's own expert, Dr. Dorothy Lewis, testified that Feldman was qualified to administer the test and had experience doing so. 1993 ROA Supp. v.1 Tr.45-46.

[23] Further, much of the evidence Hall did present on adaptive functioning was inconsistent with other parts of the record. For example, Hall's brother testified that Hall could not drive, JA202, yet it is undisputed that Hall drove Hurst from the abduction site to the murder site, and that he drove in the high-speed chase following Deputy Coburn's murder. Hall's brothers testified that Hall was illiterate and could not read or write, JA199, 212, yet the record contains items such as a letter that Hall wrote to his girlfriend shortly after the murder, 1981 ROA v.1 R.117-19, and his handwritten statement to police, *id.* at 102-05; *see also id.* at 128 (report of investigating officer noting that Hall wrote out the statement).

tive deficits prior to age 18, none of his witnesses testified regarding his intelligence before age 18. JA113. Indeed, the only quantifiable evidence on this point—Hall's 76 IQ score at age 23—supports a conclusion that Hall did not have sufficient intellectual deficits at age 18. The burden of proof was on Hall to present sufficient evidence on both additional prongs, and he failed.

Hall appears to concede that the trial court's grant of the State's motion in limine did not preclude him from presenting any evidence as to these prongs, *see* Pet'r Br. 19, 20, and he makes no real argument that the court's decision on these prongs was incorrect. Indeed, the relief Hall requests is that this Court "direct the Florida courts to consider" the very evidence of adaptive deficits that the circuit court already heard and rejected. Pet'r Br. 51-52; *see also supra* n.10.

Finally, much of the evidence—and much of Hall's argument—points to problems *other than* mental retardation, such as his difficult childhood, abusive mother, and poverty. Pet'r Br. 7, 50. Hall presented this at the sentencing stage as evidence of mitigating factors, but it does not establish mental retardation. Similarly, Hall and his experts suggest organic brain damage and mental illness, *e.g.,* JA334, but the issue here is mental retardation.[24]

---

[24] These conditions could well have affected Hall's IQ testing. *See generally* FRANCES, *supra*, at 30 ("IQ scores below 70 can be compatible with no diagnosis if there are no problems in adaptive functioning and/or if the person

Not every circumstance or condition, however sympathetic, supports an *Atkins* claim. Hall had every opportunity to prove any and all mitigating factors, and neither the resentencing jury nor the court overlooked Hall's upbringing or other issues. But ultimately, the courts found this insufficient to overcome the aggravating factors, and that issue is not before this Court. And as to the issue that *is* before the Court—whether Hall is mentally retarded—the entirety of the record shows that he is not.

Accordingly, Hall presents no basis to overturn the punishment that every jury and judge he has appeared before has found he deserves for murdering Karol Hurst.

* * *

---

was . . . suffering from another mental disorder during the time of testing.").

CONCLUSION

This Court should affirm the decision of the Florida Supreme Court.

Respectfully submitted,

PAMELA JO BONDI
Attorney General of Florida

ALLEN WINSOR
Solicitor General
Counsel of Record

Office of the
Attorney General
PL-01, The Capitol
Tallahassee, Florida 32399
allen.winsor@
myfloridalegal.com
(850) 414-3300

CAROLYN M. SNURKOWSKI
Associate Deputy
Attorney General

CAROL M. DITTMAR
Senior Assistant
Attorney General

DIANE G. DEWOLF
RACHEL E. NORDBY
LEAH A. SEVI
OSVALDO VAZQUEZ
Deputy Solicitors
General

January 27, 2014