DECLARATION OF STEPHEN GREENSPAN, PhD

I, Stephen Greenspan, declare as follows:

Background and Focus of My Evaluation

1. **I was retained by you, with payment authorization from Legal Aid of Santa Clara County. I am being compensated at the rate of $200 per hour plus travel expenses. I was asked to evaluate your client, DeShawn Campbell, a 29-year-old African-American male, who is awaiting trial for the killing of police officer Jeffrey Fontana in 2001. Specifically, I was asked to determine whether or not I believe he qualifies for a diagnosis of "mental retardation" (MR). This evaluation is part of an ongoing legal proceeding to determine whether Mr. Campbell qualifies for "Atkins" exemption from imposition of the death penalty, should he be found guilty in a subsequent trial of the crime for which he has been charged.**

2. **It is my understanding that I may get to testify at a reopening of a hearing which earlier had concluded with California Superior Court Judge Diane Northway ruling on August 17, 2007 that Mr. Campbell was not mentally retarded. As I understand it, a higher court overturned that ruling in part because of false testimony by one of the state's lay witnesses and also because Judge Northway put primary emphasis on whether Mr. Campbell qualified for a diagnosis of MR at the time of the crime and trial rather than before the age of 18.**

3. **My main task, as it was explained to me by you, is to shed light on the extent to which Mr. Campbell's adaptive functioning was in the MR range during his developmental period, namely before he turned 18. However, I was also asked to opine on whether in my professional opinion the totality of evidence available to me, including information gathered by me, supports or disputes a diagnosis of MR.**

4. **In conducting my evaluation, a variety of methods were used. I started off by reviewing (although not necessarily in great detail) the voluminous records in this case, including: legal briefs and rulings; a summary, prepared by you, of the evidence and testimony presented at the earlier hearing; reports and testimony by various experts for both the prosecution and defense; interviews and testimony by lay witnesses;**

school, medical and social security records on the defendant and other family members; police reports, including those that touch on earlier criminal charges against the defendant; and miscellaneous other items, including a CD in which the defendant was interviewed. After reviewing this material, I came to San Jose and interviewed Mr. Campbell in the Santa Clara County jail, focusing specifically on his current adaptive functioning, using a test that is a directly-administered measure of Practical Adaptive skills. The bulk of my time in San Jose was spent in conducting retrospective adaptive behavior assessments of the defendant during the developmental period, using a substantial number and variety of informants.

5. **This phase of my evaluation can be considered an expansion of earlier adaptive behavior assessments conducted in this case. It is an expansion in that: (a) I completed partial quantitative adaptive behavior questionnaires with witnesses who had earlier been interviewed qualitatively but not quantitatively; (b) I completed full quantitative adaptive behavior questionnaires on witnesses who had not earlier been interviewed; and (c) I used an instrument—the Vineland Adaptive Behavior Scale, second edition (Vineland-2)--that is different from the instrument (the ABAS-2) that had earlier been used.**

<u>My Qualifications</u>

6. **Over the past four years, I have been qualified as an expert on MR and related cognitive disorders in four or five capital proceedings in the states of Arizona, California and Colorado. In addition, I have previously been qualified as an expert on MR in family court proceedings in New Jersey and Connecticut. I am a licensed psychologist in the state of Nebraska and was previously licensed in the state of Tennessee (current status: inactive). In addition to testifying in several so-called "Atkins" proceedings, I have been a consultant (and submitted declarations) in numerous other cases. Although my work thus far has mainly been at the request of attorneys representing defendants, I have found that a claim of mental retardation was unjustified in approximately half of the cases in which I actually examined a defendant (in contrast to other cases, in which my role was limited to educating the court about the nature of mental retardation and/ or opined about the adequacy of reports by other experts.)**

7. **I am a Clinical Professor of Psychiatry at the University of Colorado Health Sciences Center, and Emeritus (retired) Professor of Educational Psychology at the University of Connecticut. I received a Ph.D. in Developmental Psychology from the University of Rochester, and was a Postdoctoral Fellow in Mental Retardation and Developmental Disabilities at the University of California at Los Angeles' Neuro-Psychiatric Institute. Before moving to Connecticut, I held academic appointments at the University of Nebraska and at George Peabody College of Vanderbilt University.**

8. **I have been elected "Fellow" (a designation given only to the most qualified members) by the Mental Retardation division of the American Psychological Association and by the American Association on Mental Retardation. I was also elected to a term as President of the Academy on Mental Retardation, which is the most prestigious research organization in the field. I have published extensively on MR, with particular emphasis on "adaptive behavior." I am a leading scholar in the MR field, as seen in the most recent diagnostic manual of the American Association on Mental Retardation (AAMR), AM. ASS'N ON MENTAL RETARDATION, MENTAL RETARDATION: DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS (10th Edition, 2002) (hereinafter "the 2002 AAMR Manual"), which cited at least twelve publications by me, more than that of any other authority. My book WHAT IS MENTAL RETARDATION, co-edited with H. Switzky (AAMR; 2003; rev. ed. 2006) has, in a short time, become one of the most-quoted reference works in the field of mental retardation and has been described by Yale professor Edward Zigler as "the best book ever written about the definition and diagnosis of mental retardation." In 2008, AAMR recognized my contributions to the field by granting me its highest honor, the Dybwad Award for Humanitarianism.**

Criteria To Use in Diagnosing Mental Retardation

9. **As described in my widely-cited book WHAT IS MENTAL RETARDATION? (American Association on Mental Retardation, 2006), MR is not always an easy diagnosis to make, especially with individuals in the range of mild MR, where virtually all Atkins applicants are likely to be found. In this brief discussion, I shall discuss the three prongs to be used in diagnosing MR, emphasizing both the letter and the spirit of those prongs.**

10. Virtually all legal definitions of MR used in the US are derived from either or both of the diagnostic manuals published by the American Association on Mental Retardation (AAMR, recently renamed the American Association on Intellectual and Developmental Disabilities) and the American Psychiatric Association, through its "Diagnostic and Statistical Manual" (DSM). The AAMR diagnostic manual has gone through several revisions, with the most recent being the tenth edition (AAMR-10), published in 2002. DSM has also gone through several revisions, with the most recent being the text-revised fourth edition (DSM-4TR), published in 2000. Starting with DSM-3 (1980), the definition of MR contained in each version of DSM has been derived entirely, except for minor wording changes, from the most current AAMR manual. Thus, the definition of MR contained in the 2000 DSM-4TR (and its 1994 predecessor, DSM-4) is derived from the 1992 AAMR-9, while it is highly likely that the definition of MR in the forthcoming DSM-5 will be based mainly on the definition of MR contained in the 2002 AAMR-10. Therefore any differences in the definitions of MR in DSM and AAMR manuals reflect the fact that the most recent DSM manual pre-dates the most recent AAMR manual, and does not reflect substantive or philosophical differences between the two organizations.

11. The definitions of MR in the AAMR and DSM manuals contain two parts: a conceptual (abstract) definition, followed by an operational (concrete) definition. While the operational definitions of MR have changed somewhat over the years, the conceptual definitions have remained essentially unchanged since they were first formulated by AAMR over 45 years ago, in the fifth edition of its manual, published in 1961.

12. The conceptual definition of MR, as reflected in both AAMR and DSM manuals, and in statutes and court opinions in California and most other states, has three parts: (a) significant deficits in intellectual functioning, (b) concurrent deficits in adaptive functioning (also known as adaptive behavior), and (c) evidence of the disorder before the onset of adulthood. As stated above, these conceptual criteria have remained essentially unchanged in various AAMR and DSM editions.

13. One difference between DSM 4-TR and AAMR-10 is that DSM 4-TR emphasizes "significantly subaverage intellectual functioning" and "concurrent deficits or impairments in present adaptive functioning" while AAMR-10 emphasizes "significant limitations in intellectual functioning and in adaptive behavior".

14. The California statute (Penal Code 1376) defining MR in criminal cases is aligned more closely with DSM 4-TR, in that it emphasizes "deficits" in adaptive functioning rather than "significant deficits". Specifically, the statute reads: "…mentally retarded means the condition of significantly subaverage general intellectual functioning … deficits in adaptive behavior … and manifested before the age of 18." This difference between "deficits" and "significant deficits" is more than a semantic distinction, in that it has implications for the operational definition that follows. The difference is that AAMR-10 applies the same criterion (approximately two standard deviations below the mean, or the second percentile of the population) for both intelligence and adaptive behavior, while DSM 4-TR applies the two standard deviation criterion only for intellectual functioning but does not specify any statistical criterion for meeting the second prong of the definition. Thus, "significant deficit" implies a more stringent criterion (typically set at the second percentile of the population) while "deficit" or "impairment" implies a much less stringent criterion, which if it is specified (not the case with DSM 4-TR or the California statute) is typically (in many other uses in medicine and psychology) at approximately one standard deviation below the mean (a standard score of 85, which indicates a percentile rank of about the 16th percent of the population). The operational criteria for diagnosing MR, and the complications involved in applying them in this particular case, are discussed briefly in the following three sub-sections and in the Findings section that follows those.

15. (1) <u>The Intellectual Criterion</u>. MR is a disorder whose core impairment is in the area of intelligence. This construct is typically measured through one's performance on an individually-administered test of intelligence which results in a full-scale IQ score that locates one's functioning in relation to the mean for the general population. IQ tests are constructed so that the population mean is set at a score of 100, with a standard deviation (an index of statistical variability) of 15. The

ceiling for MR is currently established as "approximately two standard deviations below the population mean". The term "approximately" refers mainly to the fact that no test is fully reliable and one should take various factors into account when interpreting a test number. The main thing to take into account is the fact that test scores vary approximately five points around one's "true score". As two standard deviations (2 x 15) equals 30 points, the upper IQ level for meeting the intellectual criterion for MR is 75 (100 minus 30 plus 5 [the reliability index]). In addition, one should take into account factors such as practice effect (possible learning from taking a second test too soon), changes in and adequacy of test norms (a major example of which is the so-called "Flynn effect"), and possible malingering.

16. **To summarize, the phrase "approximately two standard deviations below the population mean on a standardized test of intelligence" means that one should not rely rigidly on an IQ score number, but should take into account the adequacy of the test, the nature and meaning of the norms, the context in which the test was administered, ethnic and linguistic factors, etc. This is the main use for "clinical judgment" in diagnosing MR. As noted in the book CLINICAL JUDGMENT (AAMR, 2006) by Robert Schalock and Ruth Luckasson (two of the main authors of AAMR-10), clinical judgment in diagnosing MR is <u>not</u> a matter of relying on intuition or gut feeling (which can be misleading, especially in unqualified clinicians) but rather involves using test scores in a thoughtful and scientifically valid manner. A rigid reliance on a test score, without such thoughtfulness, can and often does result in "false positives" (wrongly concluding someone has MR when he does not) or "false negatives" (wrongly concluding someone does not have MR when he does".)**

17. **Although a clinician diagnosing MR should not rely on gut feeling (which can vary from clinician to clinician), the notion of clinical judgment (which is relied on heavily in reaching any diagnosis in the human services, not just MR) requires the clinician to interview and have some personal contact, however brief, with the person he or she is diagnosing. This is a matter of basic professional ethics and practice, and accounted for my decision to interview and have some direct contact with Mr. Campbell, even though such contact was not required for the kind of third-party adaptive behavior assessment methods that formed the main basis of my evaluation.**

18. Because, in the past, clinicians often relied rigidly and mindlessly on an IQ number, and particularly failed to take into account the five-point standard error of test scores, AAMR-10 operationally defined approximately two standard deviations below the mean as "a score below 70-75". This indicates that clinicians or agencies making a determination of MR solely on whether a score is below or above 70 are not engaging in acceptable practice. Raising the ceiling from 70 to 70-75 also reflected a policy decision that past manuals, in their concern to eliminate false positives had defined the MR class too narrowly and some loosening of the criteria needed to be undertaken to avoid the now-widespread problem of false negatives.

19. DSM 4-TR (which preceded AAMR-10) does not use the 70-75 wording. However, it is stated quite clearly that one should take into account standard error of the test and not just rely rigidly on the obtained score. In addition, both AAMR-10 and DSM 4-TR indicate that there are circumstances where reliance on a single "full-scale" IQ score can be misleading. Specifically, it is well-known that individuals with known brain damage syndromes present a mixed pattern of intellectual competence and incompetence, and summarizing across to obtain a single score can serve to obscure the true nature and extent of an individual's impairment. In such circumstances, one must be especially careful to go beyond just full-scale IQ and look at other (sometimes more qualitative) sources of data where these are available and useful.

20. Finally, the emphasis in both AAMR-10 and DSM 4-TR is on use of individualized and adequately standardized measures, and not on group administered and/ or brief screening instruments. There are only a few such individualized instruments suitable for diagnosing MR, such as the Wechsler scales (WAIS-3), the Stanford-Binet (SB-5), the Woodcock Johnson cognitive battery, etc. Group measures are not acceptable for ruling MR in or out for several reasons, the two most important being: (a) their much weaker reliability and validity, and (b) lack of information about the circumstances of administration (e.g., the possibility that someone may have received help, not been paying attention, etc).

21. (2) <u>The Adaptive Behavior Criterion</u>. For over the past 45 years, it has no longer been considered adequate to rely solely on IQ scores in determining whether one has or does not have MR. This is because IQ test scores, particularly in the "mild" level of impairment, do not always translate to other settings, and a diagnosis of MR should indicate a fairly global impairment affecting many areas of functioning. Thus, to qualify for a diagnosis of MR, one should show deficits in both IQ and "adaptive behavior". The current conceptualization of adaptive behavior relies on a "tripartite model" of intelligence and adaptive functioning that I developed over 25 years ago, and uses my work as the basis. This model has three parts: (a) "conceptual" adaptive skills (communicative and related academic competence); (b) "practical" adaptive skills (competence and understanding of physical processes) and (c) "social" adaptive skills (understanding people and social processes). In determining if someone meets the Adaptive Behavior criterion, it is necessary to show deficits in only one of these three areas (AAMR-10). Sources of data can come, preferably, from formal test scores on rating instruments (such as the Vineland-2 or ABAS-2) administered to informants, supplemented sometimes by formal test scores on individually administered measures (such as the Street Survival Skills Questionnaire), and from qualitative information gathered from affidavits, records, and observation by an evaluator.

22. The 2002 AAMR manual specified that the most important source of information regarding whether an individual meets the adaptive behavior criterion is whether one falls approximately two standard deviations (i.e., a standard score below the 70-75 range) on a standardized rating measure of adaptive behavior such as the Vineland. Two pathways to meeting the AAMR's adaptive behavior criterion were offered: (a) a standard score below 70-75 on an overall (composite) score, or (b) a standard score below 70-75 on at least one of the three adaptive skill areas of Conceptual, Practical or Social adaptive skills.

23. In establishing the possibility of being above 70-75 in one or even two of the three adaptive skill areas (or having good scores on particular items within sub-average adaptive skill areas), the AAMR wished to emphasize that having mild MR is not incompatible with being able to do many things, such as drive a car, hold a job, be married, have relatively normal language and (even) commit crimes that may require some degree of planning and volition.

24. In its USERS GUIDE, which is a supplement to the 2002 Manual and written by the same authors, the AAMR indicates that in high stakes assessments, such as an Atkins hearing, the use of retrospective ratings of adaptive behavior is often necessary, and is justified in such cases. In such retrospective ratings, raters are asked to rate an individual not as he is today but as he was at the time when the rater knew him best, living in the community. Retrospective ratings are needed because the current setting (e.g., jail or prison) does not provide opportunities to assess success or failure in more typical roles (e.g., worker) or tasks (e.g., operating appliances or dealing with neighbors). Also, MR is a disability that can best be understood as a need for supports in fulfilling such community roles and tasks. Another reason for retrospective assessment of adaptive behavior is because adaptive behavior or IQ testing may not have been carried out during the developmental period and retrospective assessment helps to establish if the individual had significant impairments during that period.

25. As already mentioned, one operational difference between AAMR-10 and DSM 4-TR, in terms of adaptive behavior/ functioning, is that DSM uses the words "limitations" and "deficits", implying either no statistical cutting score or, at most, a minus one SD (standard score of 85) criterion. AAMR-10, on the other hand, uses the words "significant deficits", implying minus two SDs (standard score below 70-75), although as mentioned, this can be accomplished either in terms of an overall adaptive composite (quotient) of 70-75 or less, or such a score in only one of the three domains of "social", "practical" or "conceptual" adaptive skills.

26. In DSM 4-TR, the criterion for adaptive functioning (the term this manual prefers, but which means the same thing as adaptive behavior) is defined as deficits in at least two out of eleven functional areas: communication, self-care, home living, social/ interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. This list is derived from AAMR-9 (1992), which was published eight years before DSM 4-TR. In AAMR-9, the adaptive behavior criterion was established as deficits in 2 out of 10 adaptive skill areas (health and safety were combined into one area, unlike DSM4-TR where they were split) or a deficit in overall composite adaptive quotient. In AAMR-10, these ten skill areas were collapsed into the three adaptive behavior domains mentioned above.

27. In the California statute (Penal Code 1376), the definition of MR is as follows: "mentally retarded means the condition of significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before the age of 18." This characterization of prong two (described simply as "deficits in adaptive behavior"), is stated globally and is not broken down into component skills or domains (unlike DSM 4-TR's 11 skills and AAMR-10's 3 domains). Because of that globality, and also because the standard is "deficits" rather than "significant deficits", the California definition appears to offer considerable flexibility (including the use of non-statistical data) in determining whether or not someone meets the adaptive behavior criterion.

28. Furthermore, one can reasonably argue that the Penal Code's using the word "deficits" to define prong two, but "significantly subaverage" to define prong one, suggests that a lower standard for meeting the adaptive behavior prong is to be used. In fact, there is a very good reason for this, as applying the minus two standard deviation criteria to both intelligence and adaptive behavior would essentially reduce the likelihood of diagnosing mild MR to near zero, as reflected in a 2002 book MENTAL RETARDATION: DETERMINING ELIGIBILITY FOR SOCIAL SECURITY BENEFITS by the National Research Council (written by a committee of which Dr. Keith Widaman was a member).

29. This book recommended a policy change to the Social Security Administration, recommending that in diagnosing MR "standardized adaptive behavior instruments should be used to determine limitations in adaptive functioning. In general, the cut-off scores for adaptive behavior should be one standard deviation below the mean in two adaptive behavior areas or one and one-half standard deviations below the mean in one adaptive behavior area" (page 205). It should be noted that in this book, published just before AAMR-10--with its one out of three adaptive domains--the adaptive behavior standard being discussed was two-out-of-ten (AAMR-9) or two-out-of-eleven (DSM 4-TR) skills. The same basic point applies, however, to more recent formulations, and that is that basic fairness requires that the adaptive functioning criterion be approached less statistically stringently than the intellectual functioning criterion if one is to avoid a grossly excessive number of false negatives (i.e., people with MR found wrongly to not have MR).

30. **(3) <u>The Developmental Criterion</u>. MR is a term indicating that an individual has intellectual and adaptive impairments which first manifested during what is termed the "developmental period". The developmental period is defined as anytime between birth and 18 (some extend the period to include gestation and entirety of one's 18th year). The purpose of this criterion is to rule out those who developed normally in childhood and adolescence, but whose impairments first manifested in adulthood, such as through a motor vehicle accident. Information about whether one meets the developmental criterion can come from a variety of sources, such as medical or school records and testimony by teachers, family members and peers.**

31. **One of the controversies in interpretation of the developmental criterion involves whether or not one needs test data (IQ or adaptive functioning) that meets the 70-75 standard, obtained during, or retroactively referenced to, the developmental period. There are some who adhere to such a strict standard, but my view is that a broader and more flexible interpretation of prong three is justified. In such a more flexible approach, all that is needed to satisfy the developmental criterion is to show that when a person qualifies as having MR as an adult, there were precursors or indicators that developed or were evident during the childhood or adolescent period. In other words, a diagnosis of MR would be inappropriate if a child was of average or above average intellectual and adaptive functioning prior to 18 but suddenly showed a steep decline, perhaps because of a brain infection or injury that developed during adulthood. Outcome-based evidence, such as a child being retained in elementary school (which occurred in this case), very low academic achievement (also true in this case), assignment to special education (also true in this case), and receipt of social security disability funding with a label of MR (also true in this case) should easily satisfy the developmental criterion, even in the absence of formal IQ or adaptive behavior data collected during that period. However, in line with my charge to flesh out the retrospective adaptive behavior assessments previously done in this case, I collected data which could be used even if a stricter standard were to be applied.**

My Findings Regarding Whether DeShawn Campbell has MR

32. **It is my conclusion that DeShawn Campbell qualifies for a diagnosis of MR. My reasons flow from my finding that he meets all three of the definitional prongs. These are discussed under each of the prongs below.**

33. **Intellectual Functioning Prong. In her opinion, Judge Northway indicated that the first prong was satisfied, both currently and retroactively to the developmental period. This certainly is my conclusion, and I shall not comment at length on this prong. Full-scale IQ scores obtained on Mr. Campbell are summarized in Table 1. All of the IQ tests obtained for Mr. Campbell are well under the 70-75 ceiling for prong one, and these scores would be even lower if the Flynn effect (a correction for obsolete norms) were taken into account.**

TABLE 1--IQ SCORES OBTAINED FOR DE SHAWN CAMPBELL

PSYCHOLOGIST	YEAR	AGE	TEST	full-scale IQ SCORE
DR. DUNCAN	1997	18	WAIS-R	65
DR. WATSON	2005	26	SB-5	66
DR. RILEY	2005	26	WAIS-III	63

Because of the effects of Larry P. v. Riles, which forbade the use of IQ tests by California schools to guide special education placement for African-American youths, no IQ data was obtained for Mr. Campbell when he was attending elementary or high school. However, there is ample evidence of severe academic failure and extremely low scores on educational measures which, although not technically IQ tests, are highly correlated with them.

Thus, the clear thrust of the test and other data available to me indicates that Mr. Campbell meets prong one (significant deficits in intellectual functioning) needed for a diagnosis of MR.

34. **Adaptive Functioning Prong. The main focus of my evaluation of DeShawn Campbell was on his level of adaptive functioning. While I did assess current adaptive functioning to some extent, I mainly focused on his adaptive functioning within the developmental period. That focus**

was driven in part by Judge Northway's concern that a single ABAS-2 profile, furthermore one obtained from Mr. Campbell's possibly biased father, was not sufficiently convincing. My focus on adaptive functioning within the developmental period was also driven to some extent by the appellate court's ruling that deficits before the age of 18 are particularly relevant in making an Atkins determination.

35. **<u>Current Adaptive Functioning</u>. Although the main focus of my evaluation was, as mentioned, on adaptive functioning during the developmental period, I felt that some assessment of Mr. Campbell's current adaptive functioning would be useful. Current adaptive functioning is most typically evaluated through a rating instrument, such as the ABAS-2 or the Vineland-2 (the two instruments which, along with the SIB, are most widely used in clinical assessments.) However, using a rating instrument to evaluate the adaptive functioning of someone in a highly restricted jail or prison setting is difficult, if not impossible, for a number of reasons. These reasons include the difficulty in finding raters but more importantly, the absence of opportunities to perform many of the behaviors (such as cooking or using public transportation) that are items on such instruments. Furthermore, a major purpose underlying the development of these instruments was to assess the supports needed to live successfully in the community, and to face the kinds of challenges and ambiguities one would find in the community. Obviously, jail is a setting that provides few such challenges and ambiguities.**

36. **A common mistake that is often made when evaluating the adaptive functioning of someone in jail is to look at his level of adjustment, such as through the presence or absence of discipline write-ups. Some experts, usually those testifying for the state, will look at a defendant who is not a discipline problem and conclude that he could not have MR. The problem with such a conclusion is that adjustment in jail is typically a matter of whether or not one has a cooperative versus hostile personality, and being a cooperative and pleasant person in no way rules out MR. In fact, it is likely the case that people with mild MR, assuming they do not also have mental illness, will tend to be more apt to go along with rules and orders, in part because such a tendency generally served them well in covering up their limitations in work, school and other settings in the community. Furthermore, there are**

relatively few choices one has to make in jail or prison, and the rules are few, clear and unambiguous. So it is fair to say that people with mild MR are likely to adapt better in a highly structured setting such as jail, and such adjustment in no way can be used to infer how impaired one's adaptive functioning would be in the community.

37. For these reasons, to assess one's level of current adaptive functioning in jail, one would most likely have to rely on one of the few "direct" measures of adaptive functioning. The one most widely used in diagnosing MR is the "Street Survival Skills Questionnaire" (SSSQ). This measure is direct in the sense that a psychologist presents everyday problems to a subject (such as figuring out a paycheck) and seeing whether the subject passes such items. The SSSQ is mainly a measure of the "Practical Adaptive Skills" domain of adaptive functioning, and it does have population norms, although these may now be somewhat obsolete.

38. On March 14, 2008 I administered the SSSQ to Mr. Campbell. This test has 180 items in which a subject is presented with an object or process and then picks the correct one out of four pictures that depicts the object or process. Mr. Campbell obtained a standard score on the SSSQ of 68, which is below the ceiling of 70-75. This is one indicator that Mr. Campbell currently meets the AAMR-10 adaptive behavior criterion of significant deficits in at least one out of the three adaptive domains (in this case, Practical Adaptive skills).

39. I also administered some items from a measure of social judgment currently being developed by me (norms are not yet available). Mr. Campbell showed dramatically poor social judgment. Specifically, he endorsed certain courses of portrayed social action (for example, a little girl believing a stranger's request to come in his car to help him find his lost dog) that the majority of cognitively average adults would likely see as very dangerous and poor choices. Such poor social judgment is a hallmark of people with mild MR and, again, is an indicator that Mr. Campbell meets the AAMR-10 standard (in this case, in the domain of Social Adaptive skills).

40. Before testing Mr. Campbell on the SSSQ, I administered the Dot Counting Test, which is one of the most used and respected measures of possible malingering on cognitive tasks. This test shows pictures with

dots and the task is to count them correctly and in a short period of time. Mr. Campbell made zero mistakes, and this fact plus the very short average time per picture gave very strong indication that he approached the testing situation in a fully attentive and effortful manner. Thus, I concluded that the SSSQ scores were valid and lacked any indication of malingering. This conclusion was also supported by clinical data such as the fact that he took a great deal of time before responding, got over half of the items correct (just as one would expect, based on the age norms, for someone with MR), and appeared to me to be giving substantial effort.

41. Qualitative data also suggests that Mr. Campbell meets the adaptive behavior criterion in adulthood. Such data include the fact that he never lived independently, apparently never mastered even minimal cooking or other domestic skills, never held a job for long, was qualified for Social Security Disability (with a diagnosis of MR) and was considered "slow" and easily led by peers.

42. I agree with Dr. Keith Widaman's testimony to the effect that *ad hoc* anecdotal evidence-- lacking norms or information about context--does not in itself provide an adequate basis for determining if a defendant meets the adaptive functioning prong. However, I think his point has to be qualified, as I believe prosecution expert Karen Salekin did quite nicely in her testimony. Specifically, what she said is that MR is a disorder ruled in by evidence of incompetence, but not necessarily ruled out by evidence of competence. This is in line with the 1-out-of-3 AAMR-10 adaptive criterion, in which one must demonstrate significant deficits in only one out of three areas. Following that line of logic, the fact that someone is competent in some domains of functioning (even assuming that the evidence is valid) does not rule out MR.

43. Dr. Salekin gave the following very apt example: the fact that someone drives an automobile (which Mr. Campbell, along with many people with mild MR, could do) does not rule out a diagnosis of MR. However, the fact that someone would do something very incompetent in the course of using a car in a crime, such as abandoning a car near the scene of a crime (an example used by Dr. Salekin), could be used to buttress the view that the person meets the adaptive functioning prong for a diagnosis of MR. Extending this example, the fact that someone finally obtained a driver's license does not rule out MR (for example, one

cannot know what help he might have obtained from a sympathetic clerk, or the possibility that some learning might have occurred after many failures). But the fact that an individual initially failed the written test numerous times (as was apparently the case with Mr. Campbell) is congruent with, and supportive of, a diagnosis of MR.

44. While AAMR-10 is the first MR diagnostic manual in which use of a standardized adaptive behavior measure, and a statistical criterion, was recommended, there was also great emphasis on the possible use of qualitative and descriptive data. In particular, AAMR-10 indicated that such data might be needed in assessing such Social Adaptive behaviors as gullibility and social vulnerability, areas which are not adequately tapped by the standardized adaptive behavior measures currently in use.

45. <u>Adaptive Functioning Before the Age of 18</u>. In her opinion, Judge Northway indicated that she did not consider Robert Campbell, Sr. a credible source of information about his son's adaptive functioning, because of the likely bias stemming from his role as a father. She also expressed the view that it was insufficient to rely on only one rater (necessitated because the ABAS-2 obtained from another rater, DeShawn Campbell's mother, was considered invalid by Drs. Patton and Watson). While Drs. Patton and Watson were reluctant to do partial ABAS-2 interviews (such as with teachers, who likely could not rate Mr. Campbell on Practical adaptive items because they mainly tap home living skills), Judge Northway indicated that such partial assessments could and should have been done. She also indicated a desire for the use of other sources of data besides the sole reliance on the ABAS-2. The judge opined that while other friends and family would also be potentially biased, the information could still be valuable, especially if it was congruent with data obtained from professionals, whom she saw as inherently more believable.

46. In line with Judge Northway's analysis of what a more adequate adaptive behavior assessment would look like, I approached the task of conducting retrospective assessments of Mr. Campbell's adaptive functioning as follows: (a) I used another rating instrument, specifically the Vineland Adaptive Behavior Scale, second edition (Vineland-2), which prosecution expert Dr. Salekin described as the gold standard of quantitative adaptive behavior measures; (b) I obtained partial

Vineland-2's from a number of professionals who could rate him on two (or one) of the three domains, but not all three; and (c) I obtained full Vineland-2's from several acquaintances and family members, including a re-interviewing (this time with the Vineland-2) of Robert Campbell, Sr.

47. The Vineland-2 (Survey Form, which is the option I chose) is filled out by an examiner while asking specific questions of an informant. The Vineland-2 labels its domains somewhat differently than does the ABAS-2, but basically taps the same three AAMR-10 adaptive domains. The three domains on the Vineland-2 are labeled: "Communication" (which taps basically what AAMR-10 calls "Conceptual Adaptive Skills"); "Daily Living Skills"(which taps what AAMR-10 calls "Practical Adaptive Skills") and "Socialization" (which taps what AAMR-10 calls "Social Adaptive Skills"). In addition, one sums across all of the items on the scale to obtain a Composite (overall) quotient, just as one does for the ABAS-2.

47. Table 2 lists all of the informants whom I interviewed, information about their relationship with Mr. Campbell, and the retrospective age they were asked to keep in mind when answering the questions (this age, always before the age of 18, was generally picked to coincide with an age where the informant had a great deal of contact with Mr. Campbell). Table 2 also lists the standard scores obtained on each of the four summary indices, where these were obtainable. All but one of the interviews were conducted in person by me, with no one else in attendance. One of the interviews (with Ms. Wonders, a former teacher) was conducted by me over the phone, as she no longer resides in California. The interviews took between 60 and 90 minutes to conduct and were not recorded.

48. The Vineland-2 differs in a few other respects from the ABAS-2: (a) while the ABAS-2 has different forms for different ages, as well as types of informants, the Vineland-2 uses a single form for all ages and relationships [this should be explained: there are two basic forms—the Survey, which is filled out by the examiner through an interview, and the teacher-caregiver Rating, which is filled out by the informant; however all of the items and norms are the same, and the Survey, which I used, can be administered to any category of informant]; (b) while the ABAS-2 items are roughly gradated from easy to hard within each

domain, in the Vineland-2 these have been empirically validated, and one uses only items that apply to the subject, making the assessment much easier to carry out.

49. That is done by establishing a "basal" (the point below which a subject gets full credit for each item) and a "ceiling" (the point after which a subject gets zero credit for each item). These points are established by moving forward until a subject gets partial or no credit after passing four successive items, and then stopping at the point at which a subject misses four consecutive items; (c) while the ABAS-2 and Vineland-2 items are generally the same for Conceptual and Practical Adaptive skills, the instruments differ somewhat in the domain of Social Adaptive skills, with the Vineland-2 in my opinion being more adequate. Specifically, the ABAS-2 has too many items that basically measure "niceness" (which is not particularly indicative for or against a diagnosis of MR) while the Vineland-2 has more items that measure social awareness and judgment (which are indicative of MR versus non-MR). For this reason, a subject who has MR is likely to receive a higher standardized score on the social domain of the ABAS-2 than on the social domain of the Vineland-2.

50. I interviewed eight adult informants, and these fell into four general categories: (a) family (the father R. Campbell, and older half-sister, A. Campbell) who knew the defendant intimately in the home setting; (b) unrelated peers (J. Huffman, J. Underwood) who knew Mr. Campbell very well from the street scene in the neighborhood; (c) an unrelated older adult (E. Barbary), who was a friend of the family, and who knew the defendant very well from a karate school where he was an instructor and knew the defendant very well both from there and from visits to the home; and (d) professionals (M. Harris, G. Wonders and M. Shulman) who knew the defendant in either elementary school or middle school and knew him mainly in the academic and social context of the school setting.

51. The upper portion of Table 2 shows the Vineland-2 results obtained by me on these eight informants. The lower portion shows the results (adjusted after some scoring issues) obtained some months earlier by Drs. Patton and Watson using the ABAS-2. In conducting the retrospective interview, I asked Mr. Campbell to use the reference age of 10-6, while Drs. Patton and Watson asked him to use the reference ages

of 16 to 17. Interestingly, in spite of using different reference ages, and different instruments, an identical score of 58 (well under the cutting score of 70-75) was obtained on overall adaptive Composite and an identical score of 59 was obtained on Conceptual.

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TABLE 2-- RETROSPECTIVE VINELAND-2 ADAPTIVE BEHAVIOR SCORES OBTAINED ON DE SHAWN CAMPBELL BY STEPHEN GREENSPAN, PhD

RATER	ROLE	AGE FRAME	VINELAND-2 STANDARD SCORES			
			CONCEPTUAL (communicative)	PRACTICAL (daily-living)	SOCIAL (socialization)	COMPOSITE QUOTIENT
R. CAMPBELL	FATHER	10-6	59	58	59	58
E. BARBARY	FAM. FRIEND	15-0	52	43	54	50
J. HUFFMAN	PEER	15-0	64	81	67	69
A. CAMPBELL	SISTER	15-0	45	25	26	28
J. UNDERWOOD	PEER	12-6	67	73	83	73
M. HARRIS	TEACHER	9-6	57	-----	-----	-----
G. WONDERS	TEACHER	12-6	62	-----	59	-----
M. SHULMAN	TEACHER	14-0	63	-----	80	-----
(ADJSTED ABAS-2 SCORES OBTAINED BY DRS. PATTON AND WATSON USING R. CAMPBELL, SR. AS THE INFORMANT)						
R. CAMPBELL	FATHER	16 to 17	59	63	81	58

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52. The overall pattern of scores differed somewhat, with both myself and Drs. Patton and Watson finding the defendant equally (and very significantly) low on Conceptual and Practical adaptive skills, but Patton/ Watson finding him significantly higher (and above the 70-75 ceiling) on Social adaptive skills. This difference could reflect the fact that the Vineland-2, as mentioned earlier, is more sensitive than the ABAS-2 to the kinds of social incompetence characteristic of people with mild MR or it could reflect the fact that Mr. Campbell might in fact have become significantly more socially competent between the age (10-6) referenced by me and the ages (16 to 17) referenced by Drs. Patton and Watson in their ABAS-2 interview.

53. Drs. Patton and Watson stated that in their clinical judgment Mr. Robert Campbell, Sr. was a reliable and truthful informant and that was certainly my impression as well. There were several factors that

entered into this opinion: (a) he labored long and hard over each answer, and it appeared to me that he was trying to be truthful; (b) his responses were very varied, that is he produced answers with an almost equal mix of scores, ranging from "2" (could usually do it), to "1" (could sometimes do it) to "0" (could never do it) responses. This mixed pattern argues against the view that he trying to give only low answers; (c) his summary score pattern on my interview (except for Social) was very similar to the earlier one, and such a degree of convergence (especially on the overall Composite standard score) is in my view impossible to fake; and (d) most importantly, his scores were highly congruent with scores obtained from six of the other seven informants.

54. Using the same considerations that led me to conclude that Mr. Campbell Sr. gave truthful and valid responses also led me to conclude that his daughter (and DeShawn Campbell's older half-sister, who functioned as a kind of surrogate mother for several years) gave untruthful and invalid responses. Her composite standard score (28) would put her brother in the range of severe or profound MR, which is grossly too low. For example, she indicated that her brother at age 15-0 was incontinent both during the day and night, and no other witness gave such information. She responded in a very quick and non-thoughtful manner and virtually every rating was a zero. Because her Vineland-2 scores were so much lower than any others, I concluded that her scores could not be used, for reasons similar to those used by Drs. Patton and Watson with regard to Susan Campbell, DeShawn's mother.

54. 55. Eric Barbary has a very responsible job as a foreman at a company based in Sacramento. I interviewed him in his very nice home in a gated community in Stockton, California. He is someone who had been interviewed by Dr. Patton, but not formally for an ABAS-2 rating. He has been described as DeShawn's karate instructor, but according to Mr. Barbary he spent a great deal of time with the Campbell family both at the karate school (owned by the senior Mr. Campbell) and in the home, and knew DeShawn well enough to do a full Vineland-2 on him. We used the age 15-0 as the reference age. To the best of my knowledge, Mr. Barbary had not been in touch with the family for awhile and I saw no sign that he was slanting his answers in any way. Mr. Barbary saw DeShawn as very impaired, and felt that his father (with whom he never talked about his son's impairment) tended to minimize the full extent of his son's impairments. This is reflected in Mr. Barbary's summary

Vineland-2 scores) which ranged from five to fifteen points lower than those which I obtained from the father. Thus, while the father (composite of 58) placed the defendant at the low end of the mild MR range, Mr. Barbary (composite of 50) placed him at the high end of position at Hewlett-Packard. The other, J. Huffman, is currently attending a junior college and is planning to become an accountant. They both saw DeShawn as impaired, but their composite scores were higher than those obtained from other informants, with Mr. Underwood's composite (73) being just under the 70-75 ceiling, and Mr. Huffman's (69) being a little lower. Both of these informants gave DeShawn standardized scores below 70 on two of the three Vineland-2 domain, and above the 70-75 ceiling on one of the domains: Mr. Underwood gave him an 83 on Social adaptive skills, while Mr. Huffman gave him an 81 on Practical.

56. The other three informants were all teachers who knew and worked with the defendant at different grades in either elementary or middle school. I interviewed one of the informants, Ms. Shulman, at the school where she is still working, while I interviewed the now-retired Ms. Harris at her home and the moved-away Ms. Wonders by phone. All three teachers told me that even though many years have elapsed, they considered DeShawn to be one of their two or three most memorable students and they felt confident that they could retrospectively rate him validly, at least for his behavior in the school setting.

57. As expected, none of the three teachers felt able to rate DeShawn on Practical adaptive skills, because so many of those behaviors could only be observed in the home. Both Ms. Wonders and Ms. Shulman saw him in the schoolyard as well as the classroom, and were able to rate him on Conceptual and Social items. Ms. Harris worked with the defendant on a one-on-one basis in the library (she was the school's librarian and also taught library and language arts) after seeing how he was taunted and made fun of in group settings. For that reason, Ms. Harris felt able to rate DeShawn only on Conceptual adaptive skill items.

58. All three teachers placed the defendant squarely in the middle or lower part of the mild MR range on Conceptual adaptive skills (scores of 57, 62 and 63). As mentioned, Ms. Harris proved unable to answer enough items on Social, because she worked with him mainly one-on-one. Ms. Wonders (reference age of 12-6) gave the defendant a Social score of 59,

well within the mild MR category, while Ms. Shulman (reference age of 14-0) gave him a Social score of 80, which while lower than average is above the 70-75 ceiling.

59. Interestingly, Ms. Shulman is the only one of the three teachers who volunteered to me that she did not feel that the defendant qualified for a label of MR. Her stated reason was that in her experience, people with MR don't have friends, while she knew that the defendant hung out with peers from his neighborhood (even though she emphasized to me that DeShawn's peer relations within the school were very poor, as reflected in the fact that he got into constant fights and arguments). To me, this is an illustration of why asking someone if a subject has MR is of little diagnostic value, as one can never know, even in a trained professional, what mistaken stereotype or bias is influencing their response. (Social competence in people with MR has been my field of studies for over 30 years, and I can state unequivocally that Ms. Shulman is mistaken in assuming that one cannot have friends and still have MR).

60. In sum, the results from my Vineland-2 interviews provides a very consistent and congruent picture of DeShawn Campbell as someone whose adaptive functioning during various ages within the developmental period were squarely in the range of mild-to-moderate MR. To me, these results provide important confirmation that the results obtained from the father by Drs. Patton and Watson on the ABAS-2 were valid, as was their conclusion that the defendant met prong two of the MR definition. I would go beyond their conclusions, and state unequivocally that this is one of the strongest of the Atkins claims that I have evaluated. Whatever doubts might have existed about the incomplete state of the evidence pertaining to adaptive behavior before have now been completely erased in my opinion.

61. (c) <u>Developmental Prong.</u> As indicated earlier, this prong can be interpreted narrowly (meaning that one must show test or other quantitative as well as qualitative evidence that could cause a diagnosis of MR to be met prior to 18) or more broadly (providing evidence that adult impairments can be traced to indicators of failure, low functioning or causation evident prior to 18). Using either approach, there is no doubt in my mind that Mr. Campbell satisfies this prong. This view was also expressed by Judge Northway in her ruling.

Conclusion

62. It is my professional opinion, to a high degree of psychological certainty, that DeShawn Campbell meets all three criteria for a diagnosis of mild MR, regardless of whether one is using DSM 4-TR, AAMR-10 or Penal Statute 1376.

63. Judge Northway previously ruled that Mr. Campbell met the intellectual functioning prong and the developmental prong. Therefore I shall summarize only the data for the adaptive functioning prong, where Judge Northway indicated earlier that insufficient evidence had been presented to support the defendant's MR claim.

64. In line with the judge's expressed preference, I used additional methods (the SSSQ and the Vineland-2) not used earlier. I also obtained partial quantitative adaptive ratings (using the Vineland-2) from professionals who could only rate the defendant retrospectively on one or two of the domains. I also obtained full Vineland-2 results from four other people able to rate the defendant on all of the items.

65. I discounted the overly-low Vineland-2 results from the defendant's half-sister, but found the other seven profiles (including from the father) to be generally quite congruent, and very consistent with a diagnosis of MR. In addition, the defendant scored below the 70-75 cutting score on a direct measure of adaptive behavior, the SSSQ, that I administered to him. These scores, in combination with a host of anecdotal and qualitative information make me extremely confident that Mr. Campbell qualifies for a diagnosis of MR, and that his disability was very clearly manifested during the developmental period.

66. I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct. Executed this 26th day of April, 2008.

Stephen Greenspan, PhD

SUPPLEMENTAL DECLARATION OF STEPHEN GREENSPAN, Ph.D.

I, Stephen Greenspan, declare as follows:

I have conducted additional adaptive behavior assessments pertaining to the mental retardation evaluation of DeShawn Campbell. My reasons for conducting this additional assessment, as well as my findings, are spelled out below.

Background

1. In his cross-examination, the prosecutor, Mr, Liroff, asked why I did not use the Teacher Rating Form for the Vineland-2, on the three teachers whom I interviewed (Harris, Wonders and Shulman) instead of the Survey Interview Form. His implicit suggestion that the Teacher rating form would have produced different results struck me as a hypothesis that was worth testing. So I purchased the Teacher rating package from the publisher of the Vineland-2 (the package consists of a different manual and several rating forms) and re-interviewed the three aforementioned teachers using the Teacher rating form of the Vineland-2.

2. Because I am in Colorado at the moment, all three of the interviews were conducted (earlier today, on Wednesday August 27) by telephone. With the Survey form, only Ms. Wonders, who resides in Wisconsin, had been interviewed by telephone. However, as I indicated in my testimony, my own experience is that the results obtained by telephone on adaptive behavior interviews are equally valid as those obtained from an in-person interview.

3. In conducting these additional interviews, I am not conceding that the Survey Interview is inappropriate for use with teachers. In fact, the Survey manual makes it quite clear that it is appropriate to interview teachers using the Survey method. In fact, if one compares the content of the Teacher Rating with the Survey Interview forms, the content for two of the domains—Communication (equivalent of Conceptual on the ABAS-2) and Socialization (the equivalent of Social on the ABAS-2)--are quite similar (the wording on some items is a little different, but the items are largely the same). Thus, I anticipated that the obtained standard scores from the two forms would be quite similar on those two domains, with any difference

reflecting mainly the fact that no psychological instrument—even one as well-constructed as the Vineland-2--is 100% reliable.

4. There are three differences between the Survey form and the Teacher Rating form for the Vineland-2. The first difference is that the Teacher form is a rating instrument, which means that one focuses on the specific items and the three possible answers, and one does not conduct an open-ended semi-clinical interview as on the Survey form. The second difference is that there is not a basal and ceiling, which means that one can ask all of the questions, although the manual does indicate that one should pick start and stop points that are appropriate to the individual being rated. The third difference is the most important (I consider the first two differences relatively trivial) and that has to do with the fact that the Daily Living (Practical) domain has items that are more oriented towards school behaviors (for example, having adequate hygiene and toileting behaviors in the school, as opposed to the home setting).

5. The fact that the Daily Living items on the teacher rating form are more school-oriented has the advantage that teachers are more likely to be able to complete the entire form, thus producing a Composite adaptive behavior score, something that is often not possible using teachers as informants with the Survey form. This is the main advantage of the teacher rating form, and the main reason why I was interested in doing these new interviews. However, I still have some questions (raised during my testimony) about the comparability of this domain on the two forms, as I have not seen research suggesting that they measure the same thing (virtually all of the research on the Daily Living/ Practical domain of adaptive behavior has been conducted with home/ community functioning in mind).

6. In addition to re-interviewing the three teachers using the Teacher Rating form for the Vineland-2, there was one additional difference. That had to do with adopting different target (retrospective) rating ages for both Ms. Harris and Ms. Wonders. Previously, with the Survey form, I had picked a target age of 9-6 for Ms. Harris and 12-6 for Ms. Wonders. However, because of evidence that Ms. Harris and Ms. Wonders had contact with DeShawn Campbell during the same academic year, I opted to pick a target (retrospective rating) age that was the same for both raters. The target age of 11-3 was selected as the age that seems most appropriate (I say “seems”

because records that would resolve that issue definitively are ambiguous or non-existent).

Results

7. A comparison of the results from the two sets of Vineland-2 assessments can be made by examining the two tables below. The first table shows the results obtained in March 2008, using the Survey form, while the second Table shows the results obtained earlier today using the Teacher Rating form.

8. As in my original declaration and earlier testimony, the Survey results all were "partial", in that no teacher rated Mr. Campbell on all three domains. Thus, none of the Vineland-2 results contained a composite (overall) adaptive behavior score. For all three of the teachers, Mr. Campbell obtained domain standard scores well under the two standard deviation cut score on "Communication" (the equivalent of "Conceptual Adaptive Skills." On "Socialization" (the equivalent of "Social Adaptive Skills") Mr. Campbell obtained a standard score (59) under the cut-score from Ms. Wonders, but over the cut score (80, which is still moderately low) from Ms. Shulman. None of the three teachers rated Mr. Campbell on "Daily Living (the equivalent of "Practical Adaptive Skills".

Vineland-2 Std. Scores Using Survey Form					
RATER	RTG AGE	comm	daily lvg.	social	composite
HARRIS	9-6	57	---	---	---
WONDERS	12-6	62	---	59	---
SHULMAN	14-0	63	---	80	---

9. The results of the re-interviews, using the Teacher Rating form version of the Vineland-2, are summarized in the Table below. All three teachers were able to complete items for all three domains, and thus were also able to produce a Composite (overall) adaptive behavior standard score. These scores provide overwhelming evidence (i.e., they go way beyond the requirement of low scores in only one of four indices) that Mr. Campbell

met prong two (adaptive functioning) of the California, AAMR and DSM criteria for diagnosing mental retardation during the developmental period.

Vineland-2 Std. Scores Using Teacher Rating Form					
RATER	RTG AGE	comm	daily lvg.	social	composite
HARRIS	11-3	58	60	76	63
WONDERS	11-3	67	73	66	66
SHULMAN	14-0	69	68	67	65

10. For Ms. Harris (reference age: 11:3), Mr. Campbell was below the minus two standard deviation cutting score on three indices (Communication/ Conceptual; Daily living/ Practical; and Composite) and was just one point (standard score of 76) over the 70-75 cut score on Socialization/ Social.

11. For Ms. Wonders (reference age: 11:3), Mr. Campbell was below the minus two standard deviation (below 70-75) cut score on all four indices, only coming close to the ceiling (standard score of 73) on Daily Living/ practical.

12. For Ms. Shulman (reference age: 14:0), Mr. Campbell was below the minus two standard deviations cut score on all four indices; in fact, none of her scores was above 70.

13. These scores are all highly congruent (within the 95th percentile confidence interval) with the scores obtained earlier on the Survey form, with one major exception, and that is that Ms. Shulman's standard score on Social/ Socialization declined from 80 to 67. Additional domains were tapped by the Teacher rating form, however, and these were all highly supportive of a diagnosis of mental retardation.

Summary and Conclusion

14. The same three teachers from whom I obtained partial Vineland

scores, using the Survey form, were re-interviewed using the Teacher Rating form. Standard scores for all four indices (Communication, Daily Living, Social and Composite) were obtained on Mr. Campbell for all three raters. The results are almost all below the minus two standard deviations (standard score ceiling below 70-75) for the vast majority of these indices.

15. The results of this re-interviewing, using the Teacher Rating form are highly congruent with those obtained earlier using the Survey form, but go beyond those results by providing standard scores on all four indices for all three raters. The results strongly support the opinion expressed in my earlier declaration, and in my testimony, namely that Mr. Campbell meets prong two of the definition of mental retardation, and that these significant deficits were manifested before the age of 18.

I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct. Executed this 27th day of August, 2008.

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Stephen Greenspan, PhD

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SUPPLEMENTAL DECLARATION OF STEPHEN GREENSPAN, Ph.D.

I, Stephen Greenspan, declare as follows:

I have been asked by Attorney Edward Sousa to comment on whether my conclusion that DeShawn Campbell had mental retardation during the developmental period has been changed by two recent sources of information provided to me: (a) the transcript of Dr. Karen Salekin's recent rebuttal testimony, and (b) the Vineland-2 teacher rating forms submitted by Dr. Lynch during recent interviews with two of Mr. Campell's high school teachers: Victoria Cobbley and Joanne Savage.

My opinion has not changed at all, and in this Declaration I summarize why that is the case.

Dr. Salekin's Rebuttal Testimony

1. Dr. Salekin testified that the Vineland-2 does not have what she considers high enough inter-rater reliability. But what really matters when using such an instrument clinically is not what is reported in the manual but what is reported by the multiple raters who I and other experts interviewed. That in fact is why one should use multiple raters, a practice that Dr. Salekin applauded in her testimony. For example, one can have an instrument with very high reliability as described in the instrument's manual, but very poor agreement across raters and testers in practice. In such a case, one would need to get additional raters, in spite of the instrument's reported reliability. Conversely, one can have an instrument (as is the case here) with imperfect reliability but extremely high agreement among raters and testers in practice. In such a case one is on firm ground in relying on the collective picture which emerges from such agreement, in spite of the reported reliability. This form of agreement, which is often termed "consensual validity", is far more important as a base for using an instrument clinically than is the instrument's reported reliability. Thus, what really counts here is not the reliability of the instrument as determined by the test authors but rather the degree of consensual validity that one obtained from its use in evaluating Mr. Campbell. In fact, there was a very high degree of consensual validity in my and others' assessment of Mr. Campbell's adaptive functioning, as reflected in the fact that almost all of the many adaptive behavior raters, across three sets of experts (myself, Watson/ Patton, and Lynch) , three different instruments (ABAS-2, Vineland-2 Survey, Vineland-2 Teacher) and many different target ages, produced scores in the range of mild-to-moderate mental retardation (MR) on two or more of the Summary indices. Such a high degree of convergence establishes conclusively that Mr. Campbell met prong two of the definition of MR, especially when integrated with the many qualitative sources of information that support such a conclusion. In short, when an instrument with less than perfect inter-rater reliability produces a high degree of consensual validity, these results are even more impressive and should be given great weight.

2. Dr. Salekin testified that one should not use the Dot Counting Test, or other measures of malingering, as they often produce false negatives in subjects with MR (in other words, their high malingering scores may reflect poor cognition rather than poor effort). This testimony would be relevant if Mr. Campbell had received a score suggesting malingering, but as he received a score suggesting non-malingering, the argument is completely

irrelevant. As I testified, a problem with the Dot Counting Test is that it combines number of errors with amount of time taken on each item, and as people with MR process information at a slower rate, they can make great effort (reflected in no or few errors) but get a poor score because they need more time. That in fact is what happened with Mr. Campbell: he clearly tried (and succeeded) in answering almost all of the items correctly, but his slower processing time put his score in the borderline range. I used clinical judgment, both from the fact that he made few errors and from what I perceived to be his thoughtful efforts on the SSSQ to conclude he was not malingering. If Dr. Salekin is suggesting that it is better to rely on clinical judgment (perceived effort and congruence across multiple tests and testers) rather than to rely on a formal malingering test, then I think I was on firm ground in concluding there was no malingering (a conclusion reached by all experts who have tested Campbell). The argument about the validity of the Dot Counting test is, thus, specious, as what should be addressed is not what test was used but the fact that no evidence of malingering was detected from many sources of data, including my own and others' clinical judgments.

3. Dr. Salekin testified that the SSSQ (Street Skills Survival Questionnaire) is not a great measure of adaptive functioning. I concur, as I testified, but as it is the only direct (non-rating) measure of adaptive functioning available, I felt it was worth trying. As with her argument with the Dot Counting Test (where a person with MR may look like he is malingering when he is not), Dr. Salekin's concern about the SSSQ is that because of too easy content it could make a subject look non-MR when in fact he actually does have MR. I agree that is a potential problem with the SSSQ, but that is not what happened. In fact, Mr. Campbell scored in the MR range on the SSSQ. Thus, the argument that the SSSQ can make a MR person look non-MR is completely specious when the results of the test support a diagnosis of MR. The MR-supporting results from a test that Dr. Salekin believes has a bias towards producing non-MR scores is, thus, even more impressive than would otherwise be the case.

4. Dr. Salekin testified that in her opinion retrospective methods should not be used when assessing adaptive behavior with a rating instrument such as the Vineland or ABAS. She clearly is in the minority on this score, as reflected in the AAIDD "User's Guide" and the fact that the consensus among experts is that they should be used in such a manner (as Dr. Salekin has herself done in the past). Dr. Salekin testified that she has changed her mind on this matter, but the changed opinion of one clinician

should be given little or no weight. I testified that the Boston panel of Atkins experts of APA Divisions 33 (MR/ DD) and 41 (forensic) supported use of retrospective use of adaptive behavior methods, and I stand by that testimony. (Mr. Liroff mischaracterized my testimony as applying to Dr. Salekin's position when it applied to the overall committee's position). Dr. Salekin testified that the committee approved such a use with the proviso that potential problems should be taken into consideration. That is in fact true of any application of testing with any test in Atkins or other psychological matters. Dr. Salekin made vague reference to "studies" which support her view about retrospective assessment but she failed to cite a single study. In fact, I saw no evidence from her CV that she possesses special expertise on memory or its limitations in retrospective assessment. Her summary of memory research pertains more to fleeting eyewitness testimony, which is very different from testimony about someone who is well-known to the witness. Furthermore, the agreement across multiple witnesses about Campbell's adaptive functioning again makes Dr. Salekin's point about the limitations of memory less than convincing (if retrospective assessment was so shaky a method, one would expect poor, rather than such strong, agreement). In sum, retrospective methods in establishing the developmental criterion on prong two is something which the field supports and for which there is no alternative. Furthermore, in line with my comment (point 1 on page 1), about consensual validity, a check against possibly faulty memory is to use multiple raters. If one obtains highly congruent results, in spite of the possible limitations of memory and retrospective responding, then the results supporting a diagnosis of MR should be seen as more, and not less, persuasive.

5. In her testimony, Dr. Salekin raised several arguments about the norms for the Vineland-2 Survey version that I also consider to be specious. She indicated that there were not enough subjects with MR, but one has to keep in mind that (as she acknowledged) political pressures have caused schools to use that label much less frequently than in the past. The question should not be what the breakdown of assigned labels is, but whether competent procedures were used to assure a representative norming sample. The publisher (Pearson Assessment) of the Vineland-2 is one of the most respected in the field of psychological assessment, and the Vineland has always been considered a very well-constructed instrument. Furthermore, as I testified, there were many other labels assigned which most likely were stand-ins for the MR label. Dr.

Salekin argued that one should use "pure" subjects (in other words subjects with only one labeled disorder) but that argument is faulty on two grounds: (a) having a label of "Learning Disabilities" rather than MR does not mean the subject has two labels, and (b) even if the subject has two labels, that is a reflection of how those labels are assigned in the real world, and the purpose of the norming process is to get a large random sample and not to focus on specific sub-groups. Dr. Salekin used the arbitrary base rate of 2-3 percent of the population and said that as the percentage of subjects in the Vineland-2 Survey version was less than one percent, it has invalid norms. But in fact, the 2-3 percent figure was derived from studies done in the 1970's and a base rate of under one percent is more accurate today, especially in school settings.

6. Dr. Salekin raised other arguments suggesting that the Vineland-2 is not appropriate for use with African-Americans. One such argument is that Blacks score lower on the Vineland-2 than Whites. One implication of Dr. Salekin's argument is that race-norming (separate norms for Blacks and Whites) should be devised, but race-norming is not an acceptable practice and has not been accepted by courts or other users of psychological tests. If norms are properly constructed, as I believe was the case with the Vineland-2, then the fact that a particular ethnic group scores lower or higher is of no relevance in deciding whether to use the test. Dr. Salekin also indicated that the Vineland-2 has lower reliability on one index for Blacks, but there are at least two other reliability indices where they scored at or above the mean. Thus, I consider Dr. Salekin's testimony about race to be completely unconvincing.

Additional Vineland-2 Ratings

7. I have been provided test reports on the Vineland-2 Teacher version, collected by Dr. Lynch from two of DeShawn Campbell's high school teachers: Victoria Cobbley and Joanne Savage. The target age was around 18 (just under for Ms. Cobbley, just over for Ms. Savage).

8. The scores for Ms. Cobbley, while higher than most of the other teachers who were retrospectively given the Vineland-2, were still supportive of a diagnosis of MR. Using the criterion of "approximately two standard deviations" (which, in line with the AAIDD admonition to take into account standard error, translates to "below 70-75") on one of the four indices, Mr. Campbell actually exceeded that standard, by qualifying on two

indices. Thus, he received a score of 73 on Daily Living Skills (which translates to "Practical Adaptive Skills") and a score of 74 on Adaptive Behavior Composite (overall adaptive functioning). The other two indices were slightly higher, but only two or three points above the 75 ceiling. These results are interesting, in that Ms. Cobbley had testified that she did not consider Mr. Campbell to have MR. But her test scores, in which she rated him retrospectively on specific skills, suggests otherwise. This again supports my contention (which I made with regard to Ms. Shulman, where the same phenomenon occurred) that what counts in assessing adaptive behavior is not the diagnostic conclusions of people unqualified to make diagnoses but rather their quantitative ratings of specific skill items.

9. Ms. Savage had a view of Mr. Campbell that was incongruent with that of other raters, including Ms. Cobbley and the three teachers interviewed by me. Her scores were the only ones of the many people interviewed by me and also by Drs. Patton and Watson, that were not supportive of a diagnosis of MR. The purpose of using many raters is to get an average picture across raters, and also to identify those raters who so far diverge from that average that their scores should be thrown out. This was done by Patton/ Watson when they threw out the mother's too-low scores on the ABAS-2 and it was also done by me when I threw out the half-sister's too-low scores on the Vineland-2 Survey form. I believe the same logic and method justifies (indeed mandates) that the same thing should be done with Ms. Savage's too-high scores. I consider Ms. Savage to be an outlier, and her scores should be thrown out. The clear consensus among all of the many other scores, including that of Ms. Cobbley, is supportive of a diagnosis of MR, and one outlier (which could reflect many factors, such as a deviant perception of Mr. Campbell or the fact that Ms. Savage used a retrospective rating age older than the developmental cut-off of 18) cannot be used to discount such convincing evidence of MR.

   I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct. Executed this 22nd day of October, 2008.

Stephen Greenspan, PhD