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April 24, 2003
Mr Chairperson , members of the committee,

My name is Larry Williams. I received my doctoral degree in Psychology in 1977 from the University of Manitoba, Canada. Immediately upon graduating from 1978-1984 I was a faculty at the Federal University of Sao Carlos- Brazil where I designed, taught in and chaired the 1st Masters program in Special Education in Latin America. I graduated 10 of the first 25 students. Today in celebrating its 25th year, the program has graduated over 200 students at the masters and Doctorate levels.

From 1985-1994 Director of several behavioral services for persons with developmental disabilities (Family, & Community services) at Canada's pre-eminent service, teaching and research center- Surrey Place Centre, Toronto Canada. I oversaw the treatment of approximately 1000 cases of persons from birth to death with Developmental Disabilities. I Trained / supervised over 50 therapists.

I am an associate professor of Psychology at UNR. I have written an introductory book on Developmental Disabilities and Mental Retardation which is now also published in Chinese and Japanese, and co-edited a book on Autism. I have an edited book on Advances in Developmental disabilities that is due out this year. I have published 8 book chapters, over 25 professional journal publications and over 200 professional conference presentations. I teach graduate and undergraduate students in an area of Psychology referred to as Behavior Analysis and its specific application in the area of Mental Retardation and Developmental Disabilities. This is also my area of Research. To this end I direct a day program for persons with Mental Retardation in which we assess and treat deficits in everyday self care and living routines, pre-academic and basic academic skills and prerequisite and basic vocational abilities, social skills and anger management.

What is at stake here is making the proper decision regarding the use of the death penalty and persons with Mental Retardation. I would like to emphasis for you that there are two central issues with respect to this decision:

1) **What is a person with Mental Retardation and why are they different from those without Mental Retardation?**
2) **Is it possible to make an accurate determination of those who have mental retardation from those who do not?**

Lets look at the first question

During even the first year of life most babies demonstrate the ability to respond to both the visual and the auditory worlds simultaneously and in ways that allow for relations or basic concepts to be learned that are typically across the auditory and visual worlds. Those who cannot do this are typically un-testable on most IQ tests. For these Mental Retardation is very clear. These people do not show any communication or social ability. For those who can, there are an ever increasing complex set of auditory – auditory, visual-visual and auditory-visual discrimination skills that make up even basic self care, and home living types of skills, let alone communication and social skills. The hierarchy of these skills is represented by the abilities measured in the typical intellectual test.

Persons who are accurately described as having mental retardation are easily seen to be different from those considered to not have mental retardation. The major obvious difference will be seen in communication, abstract reasoning, rule following and social awareness and responsibility. Whereas we observe persons with MR and dual diagnoses (MR & mental illness) to act in ways that make them "appear" to look normal to a lay audience, commonly known as the "cloak of competence" (where they have a set number of sayings they emit in certain situations, and where they have adapted to essentially behave in restricted ways in regular social situations such that no information is given that reveals their incompetence) it is impossible to fool a more sustained look at how the person reasons and behaves in everyday situations and especially in one on one interview and testing situations and sustained direct observations.

The concepts of right and wrong, regardless of their eventual meaning and complexity from different hierarchical perspectives involving other concepts such as responsibility, require at their most fundamental construction in language and cognition, a complexity that is not demonstrated in persons with mental retardation in the same sense that it is recognised as not being present in young children because they have not yet developed to that s5tage of comprehension. Lets look at the second basic question

Mental retardation is not something one can fake. Any more than one can fake having abilities they do not. The complexity of the normal human's functioning is such that both lay and even highly trained persons would find it impossible to sustain performances that could mask or fool professional analysis.

A diagnosis of Mental Retardation requires three conditions

Condition 1

1) Mental retardation is **not** determined these days by a single test of intellectual ability or an IQ test. It is however, determined **in part** by the reliable application of highly researched and standardized tests of intellectual functioning, by a qualified psychometrician (a Psychologist), trained at the graduate level in the use of such tests, their validity and their reliability. Such testing would need to produce a score that is reliably below 70 on such a test where the norm (average) would be 100 thus placing an individual at 2 standard deviations below the mean of a presumed normally distributed population. This means that the person has performed below approximately 97.5% of all possible sores with a margin of error guaranteeing 2/3 of the time an actual score falling from 66 to 74 and 95% of the time a true score of 62 to 78.

Condition 2

2) However, as support by the American Association on Mental Retardation's 1992 revised Diagnosis and Classification system **this is only part 1 of step one in a three step process.** A second component of step one, will determine if the person being assessed demonstrates significantly **subnormal functioning in at least two of ten specific areas or domains in adaptive behavior skills.** These domains are, communication, social skills, home living, functional academics, leisure, self-care, community use, self-direction, health and safety, and work.

These domains represent the two generally agreed upon adaptive behavior features of personal independence and social responsibility . As described in the AAMR (1992) system from Grossmans' 1983 description of adaptive behavior...

"Adaptive behavior refers to the quality of everyday performance in coping with environmental demands. The quality of general adaptation is mediated by level of intelligence: thus the two concepts overlap in meaning. It is evident, however from consideration of the definition of adaptive behavior, with its stress on everyday coping, that adaptive behavior refers to what people do to take care of themselves and to relate to others in daily living rather than the abstract potential implied by intelligence." (p42)

...if an individual does not have adaptive skill limitations then the diagnosis of Mental Retardation is not applicable.

Some abstract and higher order reasoning abilities are necessary for adaptive behavior success and to systematically be able to not present such abilities in two areas of adaptive behavior functioning while maintaining normal functioning in other areas has not been demonstrated to my knowledge.

So...To be diagnosed with Mental retardation one must demonstrate an intelligence test score of 70 or below, AND demonstrate significant sub normal functioning in at least two of the ten areas of adaptive behavior.

Condition 3

A third requirement for the first phase of the three phases in the AAMR process is that the demonstration of subnormal intellectual functioning (IQ below 70) and the significantly sub normal adaptive behavior functioning (two of ten domains) **must have been evident in the person's performance abilities before the age of 18.**

By definition and professional practice, it would not be possible for a person with no history or evidence of any sub normal functioning before the age of 18 to "fake" being Mentally Retarded. This of course does not apply to those having an acquired brain injury such as sustained in certain head traumas.

In conclusion: Persons with Mental Retardation are indeed different from those who do not have Mental Retardation. Those differences are seen in the ability to function at considerably complex levels in language and cognition as measured on formal abstract test performance and tests of adaptive skill deficiency. These deficiencies are different from and more fundamental than those differences seen due to Mental Illness (Psychopathology). Mental Retardation deficiencies are detectable and measurable. Such differences have not been known to be faked consistently as the superior ability required to do so would be revealed elsewhere.

As children are exempt from the death penalty so too should be persons with Mental Retardation

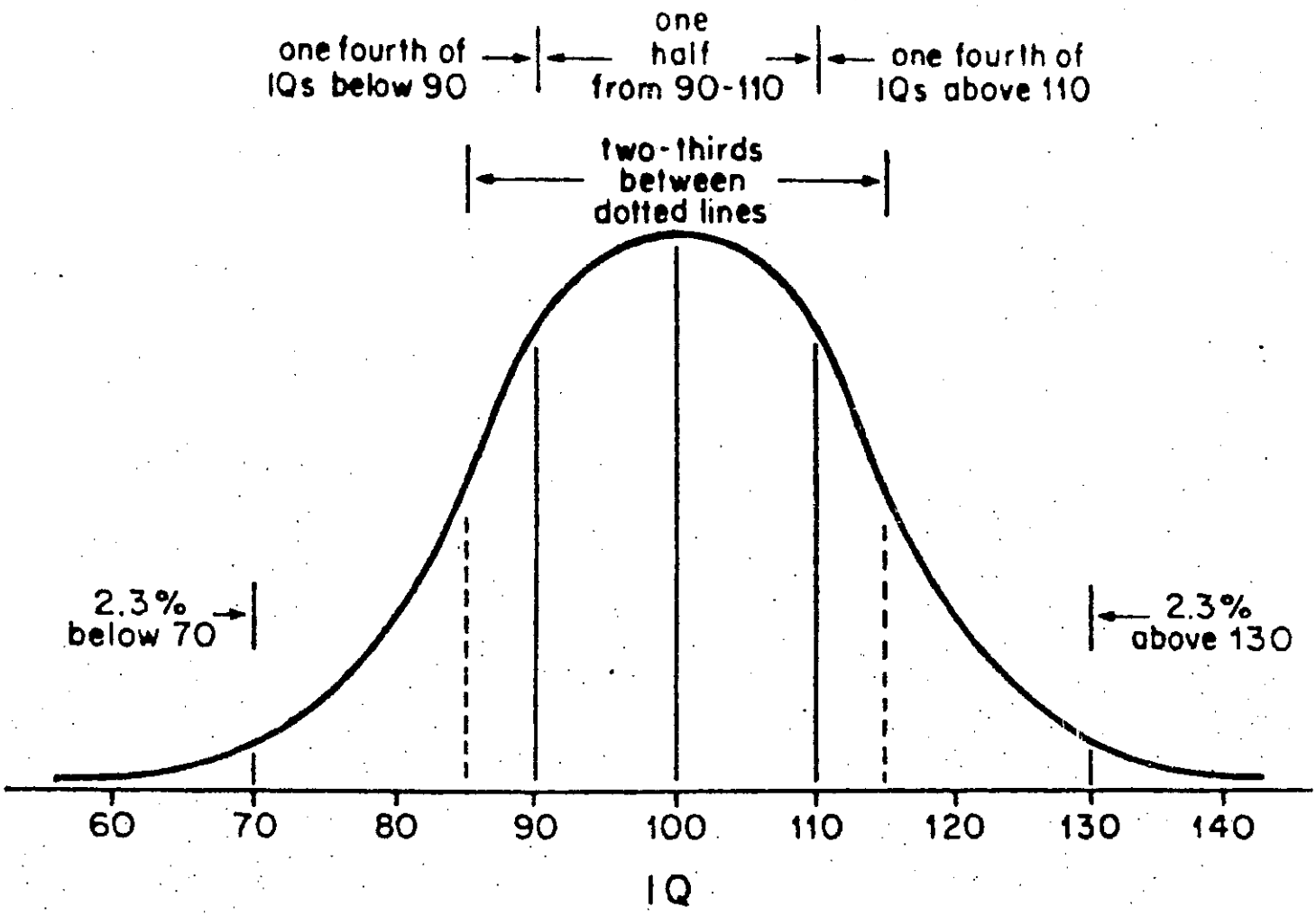


Figure 2. The "normal" distribution of IQs. This assumes a standard devi tion of 15 points, characteristic of many scales. The Stanford-Binet has standard deviation of 16 points; other scales have higher or lower values. B convention the mean IQ is always 100. The proportional values have bee rounded.

THE DEFINITION

Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in 2 or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18.

FOUR ASSUMPTIONS ESSENTIAL TO THE APPLICATION OF THE DEFINITION

1. Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioural factors.

2. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports.

3. Specific adaptive limitations often co-exist with strengths in other adaptive skills or other personal capabilities.

4. With appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

THE 3 STEP PROCESS: DIAGNOSIS, CLASSIFICATION AND SYSTEMS OF SUPPORTS

Dimension I: *Intellectual Functioning and Adaptive Skills*	STEP 1. Diagnosis of Mental Retardation *Determines Eligibility for Supports* Mental retardation is diagnosed if: 1. The individual's intellectual functioning is approximately 70 to 75 or below. 2. There are significant disabilities in two or more adaptive skill areas. 3. The age of onset is below is 18.

General Structure of the Definition of Mental Retardation

Dimension II: *Psychological/ Emotional Considerations* *Dimension III:* *Physical/Health/ Etiology Considerations* *Dimension IV:* *Environmental Considerations*	STEP 2. Classification and Description *Mental Retardation Determines Eligibility for Supports* 1. Describe the individual's strength and weaknesses in reference to psychological/ emotional considerations. 2. Describe the individual's overall physical health and indicate the condition's etiology. 3. Describe the individual's current environmental placement and the optimal environment that would facilitate his/her continued growth and development.

STEP 3.

Profile and Intensities of Needed Supports

Identifies Needed Supports

Identify the kind and intensities of supports needed for each of the four dimensions.

1. Dimension I: Intellectual Functioning and Adaptive Skills

2. Dimension II: Psychological/Emotional Considerations

3. Dimension III: Physical Health/Etiology Considerations

4. Dimension IV: Environmental Considerations

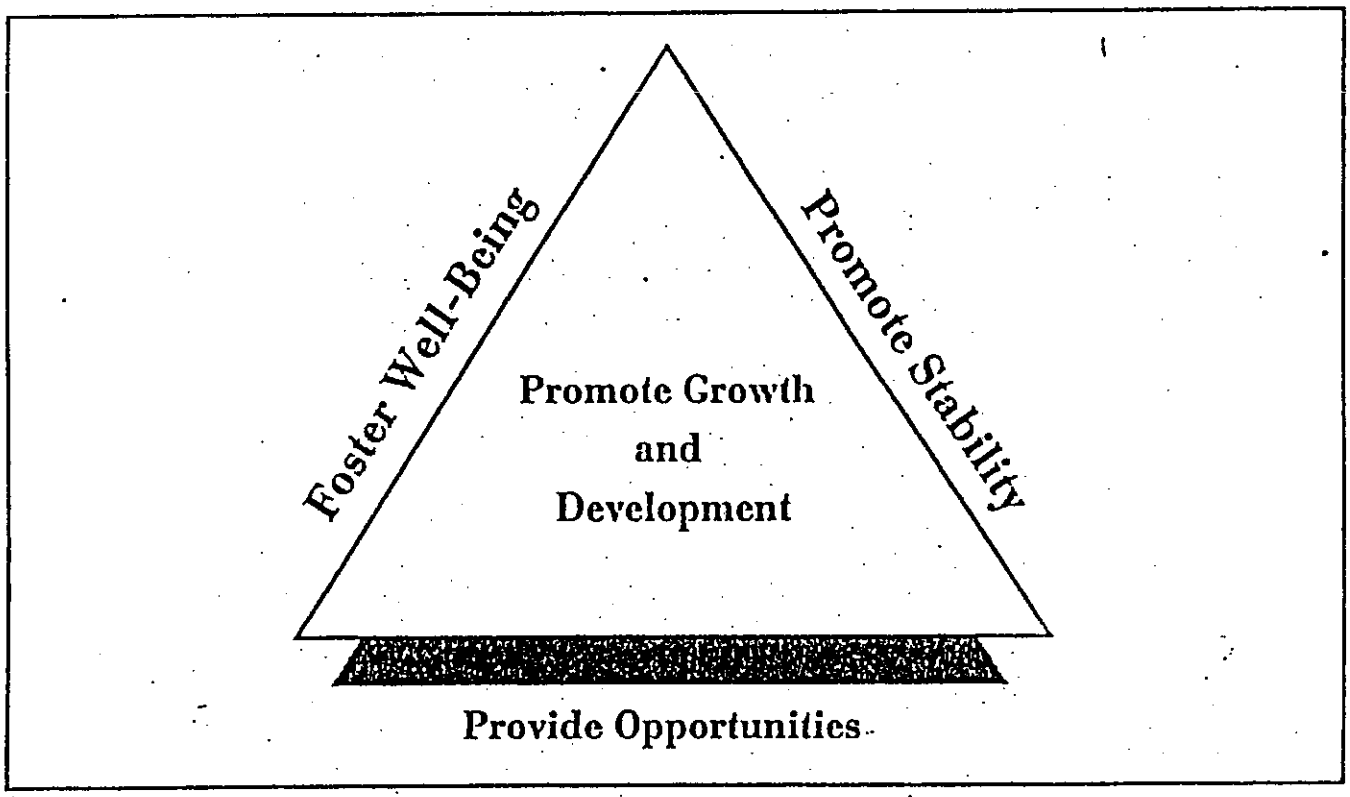
ENVIRONMENTAL CONSIDERATIONS

- The specific settings in which the person receives educational services, lives and/or works.

- The extent to which the characteristics of these environments facilitate or restrict factors that influence a person's growth, development and well-being.

- The optimum environment that would facilitate the persons independence/interdependence, productivity, community integration, social belonging, and well-being.

FIGURE 8.1 Qualities of Wholesome Environments



CHARACTERISTICS OF OPTIMUM ENVIRONMENTS

- **COMMUNITY PRESENCE:**

  The sharing of the ordinary places that define community life.

- **CHOICE:**

  The experience of autonomy, decision-making, and control.

- **RESPECT:**

  The reality of having a valued place in one's community.

- **COMMUNITY PARTICIPATION:**

  The experience of being part of a growing network of family and friends.

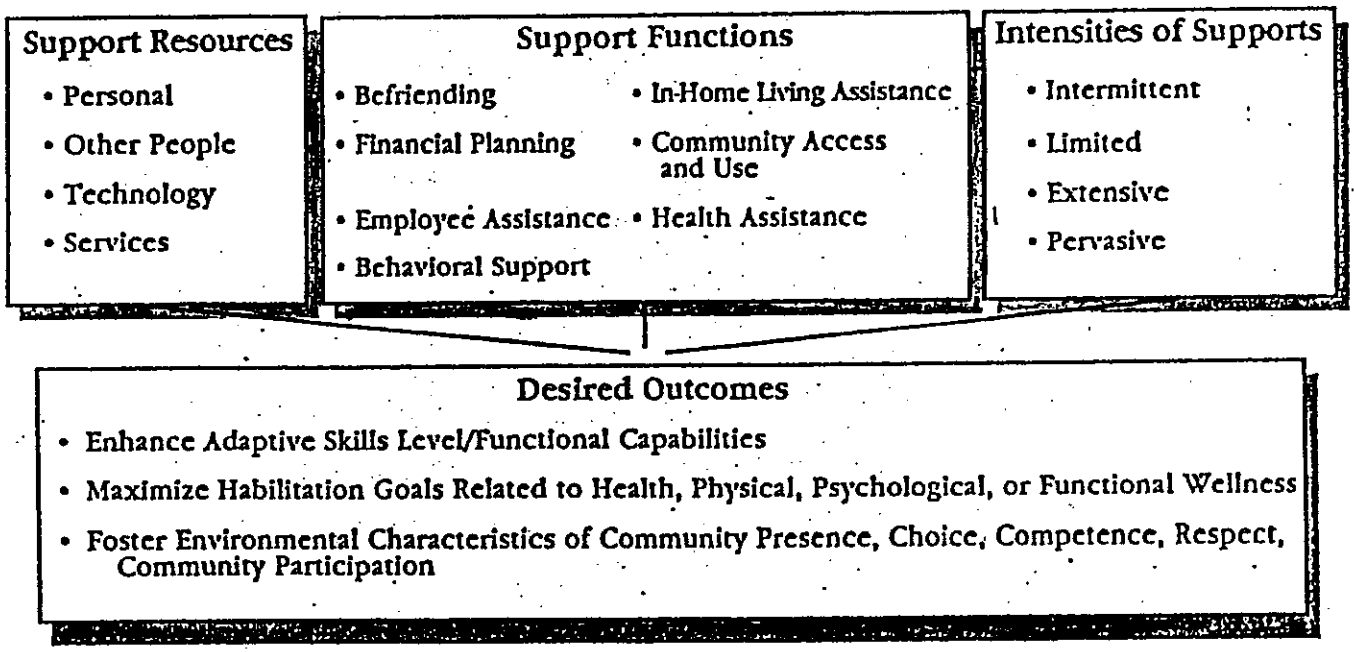
TABLE 8.1 Environmental Factors That Enhance a Person's Sense of Well-Being and Stability

Life area	Factor	Suggestions to maximize factor
Physical	Health, fitness, nutrition	Safeguard the person's health and fitness Ensure adequate medical, dental, optical, physical therapy, and nutritional services
Material	Housing, possessions, income	Allow ownership and control of one's material possessions Maximize the amount of disposable income that is under the person's control Safeguard and promote the physical quality of the home Promote quantity and quality of person's possessions
Social	Community presence	Promote access to community, such as shops, leisure facilities, and places of education Encourage a range of friends, family members, colleagues, and peers Allow choices over home, activities, possessions, and activities Develop basic abilities in communication, ability, self-help, and social leisure skills Use prosthetics and environmental accommodation techniques Stress and allow for valued social roles and activities
Cognitive	Cognitive development	Provide stimulation, education, and enriched environments Teach decision-making skills Allow choices and decision-making Develop competence and allow for choices and decision

Note: Adapted from Blunden (1988), O'Brien (1987), and Schalock and Kiernan (1990).

DEFINITION OF SUPPORTS

"Resources and strategies that promote the interests and causes of individuals with or without disabilities; that enable them to access resources, information, and relationships inherent within integrated work and living environments; and that result in their enhanced interdependence/dependence, productivity, community integration and satisfaction".


Support Resources
• Personal
• Other People
• Technology
• Services
Support Functions
• Befriending
• In-Home Living Assistance
• Financial Planning
• Community Access and Use
• Employee Assistance
• Health Assistance
• Behavioral Support
Intensities of Supports
• Intermittent
• Limited
• Extensive
• Pervasive
Desired Outcomes
• Enhance Adaptive Skills Level/Functional Capabilities
• Maximize Habilitation Goals Related to Health, Physical, Psychological, or Functional Wellness
• Foster Environmental Characteristics of Community Presence, Choice, Competence, Respect, Community Participation