No. 17-7505
(Capital Case)

IN THE
Supreme Court of the United States

VERNON MADISON,
Petitioner,

v.

STATE OF ALABAMA,
Respondent.

ON WRIT OF CERTIORARI TO THE
MOBILE COUNTY, ALABAMA, CIRCUIT COURT

BRIEF FOR THE AMERICAN PSYCHOLOGICAL ASSOCIATION AND AMERICAN PSYCHIATRIC ASSOCIATION AS AMICI CURIAE IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

CASES

DOCKETED CASES

OTHER AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

INTEREST OF AMICI CURIAE[1]

The American Psychological Association is the largest association of psychologists in the United States. A non-profit scientific and professional organization, the American Psychological Association has approximately 115,000 members and affiliates, including the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. Among the American Psychological Association's major purposes are to increase and disseminate knowledge regarding human behavior, to advance psychology as a science and profession, and to foster the application of psychological learning to important human concerns, thereby promoting health, education, and welfare.

The American Psychiatric Association, with more than 37,800 members, is the largest psychiatric association in the United States and the nation's leading organization of physicians specializing in psychiatry. Members of the American Psychiatric Association engage in treatment, research, medical education, and forensic activities, and include many who work in the criminal justice system. The American Psychiatric Association and its members have substantial knowledge and experience relevant to the issues in this case.

Members of each amicus are regularly called before courts to participate in competency hearings. Amici therefore have pertinent expertise as well as a strong interest in the establishment of legal competency

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[1] No party authored this brief in whole or in part, and no one other than amici, their members, and their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Both parties have filed blanket letters of consent to the filing of this brief.

standards consistent with the best scientific knowledge about individuals suffering from mental illness. Amici have filed briefs with this Court in similar cases, including *Panetti* v. *Quarterman*, 551 U.S. 930 (2007); *Ford* v. *Wainwright*, 477 U.S. 399 (1986); *Roper* v. *Simmons*, 543 U.S. 551 (2005); and *Atkins* v. *Virginia*, 536 U.S. 304 (2002) (via briefs submitted in *McCarver* v. *North Carolina*, *cert. dismissed*, 533 U.S. 975 (2001)).

In 2003, the American Bar Association established a Task Force on Mental Disability and the Death Penalty, which included mental-health professionals who are members and representatives of amici. The task force was convened in light of *Atkins* v. *Virginia*, to address unresolved issues concerning application of the death penalty to persons with impaired mental conditions, and in 2005 it presented a series of recommendations. *See Recommendation and Report on the Death Penalty and Persons with Mental Disabilities*, 30 Mental & Physical Disability L. Rep. 668 (2006) (hereafter *Task Force Report*), *available at* https://www.apa.org/pubs/info/reports/mental-disability-and-death-penalty.pdf. Of particular relevance here, the task force identified several situations in which it concluded the death penalty should not be applied to individuals with mental illness. One situation is where the individual, though having been determined competent to stand trial and sentenced to death, suffers from a severe mental disorder or disability that renders him or her unable to understand the nature and purpose of the death penalty. Such individuals include those whose mental illness worsens in material respects after the death sentence is imposed. Based on the task force's report, amici and the American Bar Association recommended, in sub-

stantially similar form, that the death penalty should not be applied to this category of individuals.[2]

SUMMARY OF ARGUMENT

This Court has repeatedly emphasized the humanitarian concerns underlying the common-law prohibition on executing individuals who lack the capacity to prepare for execution. *See Ford*, 477 U.S. 399; *Panetti*, 551 U.S. 930. In one case, for example, the Court explained that executing someone who is incompetent has long been considered "a miserable spectacle" of "inhumanity and cruelty." *Ford*, 477 U.S. at 407. The Court has also noted, however, that articulating standards governing *who* is legally competent to be executed presents challenges. In its most recent statement directly addressing this issue, the Court held that a prisoner must have a "rational understanding" of the rationale for an execution—while acknowledging that "a concept like rational understanding is difficult to define." *Panetti*, 551 U.S. at 959.

The court below rejected petitioner Vernon Madison's claim that he lacks a "rational understanding" of the reason for his impending execution. The court determined that he was competent to be executed even though he has experienced marked cognitive decline after multiple strokes, including impairments to his working memory, expressive capacity, and day-to-day

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[2] In addition to the recommendation discussed in the text, the task force presented, and amici and the ABA adopted, recommendations regarding individuals with mental retardation (now known as developmental intellectual disabilities) and equivalent impairments of intellectual and adaptive functioning, persons who were mentally ill at the time of the offense, and persons not competent to seek or assist counsel in post-conviction proceedings.

independence. This ruling—and the narrow interpretation of "rational understanding" that it reflects—fails to account for the common-law concerns (embraced in both *Ford* and *Panetti*) that prohibit executions of people who are incompetent.

In Part I of this brief, amici explain that based on the common law and this Court's precedent, it is cruel and unusual punishment to execute an individual with severe vascular dementia—a disease for which there is no cure, and which often causes debilitating cognitive impairments of the type that afflict Mr. Madison. In Part II, amici explain that mental-health experts can assist courts in identifying prisoners with severe dementia through the use of modern brain imaging, standardized clinical assessments, and instruments to detect malingering.[3]

[3] The leading reference on the classification of mental disorders now refers to dementia as "major neurocognitive disorder." American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 602 (5th ed. 2013) (hereafter "DSM-5"). Similarly, vascular dementia is now referred to as "major vascular neurocognitive disorder." *Id.* at 621.

ARGUMENT

I. EXECUTING AN INDIVIDUAL WITH SEVERE COGNITIVE IMPAIRMENTS CAUSED BY VASCULAR DEMENTIA CONSTITUTES CRUEL AND UNUSUAL PUNISHMENT

A. Humanitarian Concerns Rooted In The Common Law Animated This Court's Holdings That It Is Unconstitutional To Execute People Who Are Mentally "Incompetent"

This case concerns the circumstances under which a defendant with mental impairments may be executed. This Court has considered that issue twice before. In *Ford*, the Court held that "the Eighth Amendment prohibits a State from carrying out a sentence of death upon a prisoner who is insane." 477 U.S. at 409-410. And in *Panetti*—which recharacterized the inquiry as "competency" rather than "sanity," *see* 551 U.S. at 935—the Court held that a defendant is competent to be executed only if he can "comprehend[] the meaning and purpose of the punishment," *id.* at 960, and is able to "reach a rational understanding of the reason for the execution," *id.* at 958.

In both cases, the Court looked to the common law and the underlying humanitarian concerns implicated in executing an individual whose mental illness precludes a rational understanding of his punishment. In *Ford*, for example, the Court relied on the common-law prohibition on executing the insane, a prohibition grounded in several justifications. *See* 477 U.S. at 407. These justifications, the Court explained, include that executing an insane person "simply offends humanity"; that doing so "provides no example to others and thus contributes nothing to whatever deterrence value is intended to be served by capital punishment"; and that it is "uncharitable to dispatch an offender into another

world, when he is not of a capacity to fit himself for it." *Id.* (quotation marks omitted).

The Court re-emphasized these principles twenty years later in *Panetti*. In particular, the Court quoted what it described as *Ford*'s "foundation" for its holding, including (1) "serious[] question[s]" about "the retributive value of executing a person who has no comprehension of why he has been singled out and stripped of his fundamental right to life"; and (2) "the natural abhorrence civilized societies feel at killing one who has no capacity to come to grips with his own conscience or deity." *Panetti*, 551 U.S. at 957 (quoting *Ford*, 477 U.S. at 409). Applying those principles, the Court rejected an unduly narrow definition of incompetence for this purpose, rejecting in particular "the proposition that a prisoner is automatically foreclosed from demonstrating incompetency once a court has found he can identify the stated reason for his execution." *Id.* at 959. "A prisoner's awareness of the State's rationale for an execution," the Court expounded, "is not the same as a rational understanding of it." *Id.* At the same time, the Court acknowledged that "a concept like rational understanding is difficult to define," *id.*, and thus did not "attempt to set down a rule governing all competency determinations." *Id.* at 960-961. In explaining its reasoning, however, the Court repeatedly emphasized the need to consider "the principles set forth in *Ford*." *Id.* at 959.

Consistent with *Ford* and *Panetti*, amici submit that humanitarian considerations rooted in the common law should guide courts' analysis of whether executing defendants like petitioner Vernon Madison violates the Eighth Amendment.

B. The Effects Of Vascular Dementia Deprive Individuals Like Mr. Madison Of A "Rational Understanding" Of The Connection Between Crime And Punishment

The humanitarian considerations underlying *Ford* and *Panetti* apply with equal force to individuals who, like Mr. Madison, have cognitive decline associated with vascular dementia.

The severe cognitive effects of vascular dementia are prevalent and well-documented—and those afflicted by them may often lack a rational understanding of the reason why they would be executed. Executing a defendant under those circumstances would "offend[] humanity" and fail to serve "the community's quest for retribution." *See Ford*, 477 U.S. at 407-408.

1. Individuals with vascular dementia often lose the cognitive capacity to handle the demands of everyday life

Vascular dementia is a disease (often progressive) for which there is no FDA-approved treatment. *See* Raj N. Kalaria et al., *Stroke Injury, Cognitive Impairment, and Vascular Dementia*, Biochimica et Biophysica Acta 1862: 915, 921 (2016); Poornima Venkat et al., *Models and Mechanisms of Vascular Dementia*, 272 Exp. Neurol. 97 (Oct. 2015). As with any form of dementia, the symptoms of vascular dementia and the speed at which it progresses may vary. But there are several unifying characteristics, which allow for consistent diagnoses as well as an overall picture of how the disease presents.

Age-related dementia (of which vascular dementia is one type) is "an irreversible condition resulting in progressive cognitive decline," and is "one of the lead-

ing health problems of our time." Constantino Iadecola, *The Pathobiology of Vascular Dementia*, 80 Neuron 844, 844 (2013). It is "associated with a number of deficits in intellectual and adaptive functioning … and disturbances in executive functioning connected with planning, organizing, sequencing, and abstracting." *Task Force Report*, 30 Mental & Physical Disability L. Rep. at 669-670. Indeed, as the Task Force on Mental Disability and the Death Penalty explained, "the only significant characteristic that differentiates [this] severe disabilit[y] from mental retardation is the age of onset." *Id.*

The diagnostic criteria for dementia or major neurocognitive disorder are: (1) "[e]vidence of significant cognitive decline from a previous level of performance in one or more cognitive domains," including learning and memory, language, executive function, complex attention, perceptual-motor, or social cognition; (2) cognitive deficits creating "interfere[nce] with independence in everyday activities"; (3) cognitive deficits that do not occur "exclusively in the context of a delirium"; and (4) lack of a superior explanation for the cognitive deficits. DSM-5 at 602.

Vascular dementia in particular is characterized by a reduced blood flow to the brain, often caused by strokes or microvascular disease. DSM-5 at 621-622. When diagnosing vascular dementia, a clinician relies on history, physical examination, and neuroimaging. *Id.* at 622. Vascular dementia is often associated with physical deficits causing additional disability, as well as mood changes and executive dysfunction. *Id.* at 622-623.

Patients with vascular dementia following a stroke may have symptoms that are distinct from other forms

of dementia, based on the part or parts of the brain affected by the stroke. *See* Stroke Ass'n, *Factsheet 29: Dementia After Stroke* 3 (Apr. 2012), *available at* http://www.stroke.org.uk/sites/default/files/Dementia%20after%20stroke_0.pdf. These effects include incontinence, communication problems (including difficulty following conversations), and mood changes. *Id.* As the disease progresses, a patient with vascular dementia may become unable to carry out everyday tasks, including hygiene-related ones, and become forgetful and confused about his or her surroundings. *Id.* Patients in the later stages of dementia "might not be able to express themselves or understand what is said to them," and may need to use a wheelchair or become bedridden. *Id.* at 3-4. There are no approved therapies to treat vascular dementia. *See* Kalaria, *supra*, at 921. Without a way to treat the underlying lack of blood flow causing a patient's vascular dementia and repair damaged brain regions, there is little hope of stopping the disease or its progression. *Id.*

2. Vernon Madison's medical history demonstrates dementia's severe impact on cognitive function and functional activities of daily living

In earlier proceedings involving Mr. Madison, both his expert and Alabama's expert, as well as all three Eleventh Circuit judges who heard his case, agreed that Mr. Madison suffered from multiple strokes and significant cognitive decline. *See Madison* v. *Commissioner*, 851 F.3d 1173, 1179-1180, 1185-1186 (11th Cir. 2017), *vacated sub nom. Dunn* v. *Madison*, 138 S. Ct. 9 (2017) (per curiam); *id.* at 1190 (Jordan, J., dissenting). The record in those proceedings indicates in particular that Mr. Madison suffers from deteriorating cognitive

functioning. In addition to other symptoms characteristic of late-stage vascular dementia, such as incontinence and inability to walk unassisted, Mr. Madison is experiencing progressive and marked intellectual and adaptive decline. According to the report of his expert, Dr. John Goff, Mr. Madison's declining brain function has left him with a working memory score of 58 (scaled to a mean of 100)—representing a "very substantial deficit in regard to working memory." ECF No. 8-3 at 17, *Madison* v. *Dunn*, No. 1:16-cv-00191-KD-M (S.D. Ala. 2016) (hereafter "Goff Report"). Mr. Madison is also "unable to rephrase simple sentences," "perform simple mathematical calculations either mentally or on paper," draw a clock, recite the alphabet, or count by threes. *Id.* at 16-18. Moreover, his "[l]ogical memory for verbal material was very poor," and he could not recall any of the 25 elements from a brief story. *Id.* at 16.

These deficits interfere with Mr. Madison's ability to form a rational understanding of his punishment and its relationship to his crime of conviction. Mr. Madison does not remember the sequence of events from crime to arrest to trial, nor the underlying facts, including his victim's identity. Goff Report, *supra*, at 18. As Dr. Goff noted, "In terms of the reasoning behind the execution [Mr. Madison] indicates that he does not believe that he ever killed anybody." *Id.* In these circumstances, and in light of the progressive nature of his disease, there is strong evidence that Mr. Madison's understanding of the purpose of his impending execution, as well as his ability to process the explanations given to him, are severely impaired.

3. The humanitarian concerns underlying *Ford* and *Panetti* apply with equal force to individuals whose rational understanding is significantly impaired by vascular dementia

Although this Court has "established the propriety and affirmed the necessity of referring to 'the evolving standards of decency that mark the progress of a maturing society' to determine which punishments are so disproportionate as to be cruel and unusual," *Roper*, 543 U.S. at 561 (quoting *Trop* v. *Dulles*, 356 U.S. 86, 101 (1958) (plurality opinion)), this case does not call for any significant evolution beyond *Ford* and *Panetti*. As noted, the Court's decision in each of those cases was driven by various considerations grounded in common law. Common-law principles likewise require the conclusion that the execution of individuals like Mr. Madison violates the Eighth Amendment.

To be sure, given the rarity at common law of lengthy delays in carrying out capital sentences, *see Lackey* v. *Texas*, 514 U.S. 1045, 1045 (1995) (Stevens, J., respecting the denial of certiorari), it would have been quite unusual for prisoners condemned to death at common law to experience significant cognitive impairment and attendant declines in intellectual and adaptive functioning after sentencing. The infirmities associated with vascular dementia, moreover, do not always map cleanly onto the concept of a "rational understanding" of the reason for execution, *Panetti*, 551 U.S. at 956. Hence, under a narrow interpretation of that phrase, one might view Mr. Madison as having a rational understanding, given his ability to recognize that "he was tried and imprisoned for murder and that Alabama [would] put him to death as punishment for that crime," *Dunn*, 138 S. Ct. at 12.

But the common-law principles animating *Ford* and *Panetti* foreclose such a narrow interpretation of the "rational understanding" standard. As the Court explained in *Ford*, courts at common law considered whether a prisoner facing capital punishment was "of a capacity to fit himself" for death or able to "come to grips with his own conscience or deity," 477 U.S. at 407, 409. Individuals, including those with moderate to severe dementia, who lack sufficient cognitive capacity to handle the demands of everyday life cannot be said to possess sufficient cognitive capacity to do either of these. Although many of these individuals may, like Mr. Madison, appear to show some "awareness of the State's rationale" for execution, *see Panetti*, 551 U.S. at 959, their cognitive limitations preclude them from having a true "rational understanding" or appreciation of the purpose of their punishment.[4]

Executing an individual suffering from moderate to severe vascular dementia offends humanitarian principles for additional reasons that are not strictly tied to the question of rational understanding. It "simply offends humanity," and "contributes nothing to … deterrence," *Ford*, 477 U.S. at 407, to execute someone suffering the extreme physical and mental limitations that vascular dementia has inflicted on Mr. Madison. Or as the Court put it in *Ford*, "execution serves no purpose in these cases because madness is its own punishment." *Id.*.

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[4] Nothing in this Court's ruling last year in Mr. Madison's habeas case precludes this interpretation of "rational understanding." To the contrary, the Court expressly stated that it was "express[ing] no view on the merits of the underlying question [i.e., the exact scope of *Ford* and *Panetti*] outside the AEDPA context." *Dunn*, 138 S. Ct. at 12.

II. MENTAL-HEALTH PROFESSIONALS CAN RELIABLY DIAGNOSE SEVERE NEUROPATHOLOGY AND DETERMINE AN INDIVIDUAL'S CAPACITY

The conclusion that an assessment of a prisoner's rational understanding should take into account his or her overall cognitive capacities—which may be reflected in intellectual and functional incapacities more broadly—is fully consistent with the approaches of modern medicine and psychology. Psychologists, psychiatrists, non-psychiatric physicians, and other experts can reliably conduct a rigorous and reliable evaluation of capacity, and thereby provide consistent and meaningful assistance to courts in making the necessary determinations.

A. Mental-Health Professionals Can Use Brain Imaging To Diagnose Vascular Injury

Recent advances in brain imaging have made mental-health professionals particularly adept at identifying brain damage leading to dementia. Through magnetic resonance imaging and computed tomography, for example, a medically trained professional can identify the signs of cerebrovascular disease, including large vessel infarcts or hemorrhages, "strategically placed" infarcts and hemorrhages (such as in the crucial areas of the angular gyrus, the thalamus, or the basal forebrain), and white matter lesions. DSM-5 at 622. Indeed, so advanced and reliable is the technology that diagnosis of probable vascular neurocognitive disorder now requires "the demonstration of abnormalities on neuroimaging" for "[e]tiological certainty." *Id.*

Precise neuroimaging, coupled with an understanding of a patient's medical history, also allows medically trained professionals to assess the extent and location

of a patient's brain damage, and to determine what cognitive effects could be expected from this brain damage. Kalaria, *supra*, at 916. Damage to the prefrontal-subcortical circuit, for instance, can create executive dysfunction, while damage to the frontal lobe can create dysfunction in processing speed, reaction time, and working memory, and strokes in the angular gyrus, medial frontal lobe, and various other locations can lead to "strategic infarct dementia," creating diminished cognitive capacity. *Id.* When cognitive decline can be temporally linked with the patient's brain damage, moreover, the diagnosis can be even more reliable. *See* DSM-5 at 622.

B. Mental-Health Professionals Regularly Assess Capacity To Appreciate Information

Using the diagnostic technology just discussed, as well as their own evaluative techniques, mental-health professionals regularly evaluate an individual's capacity to appreciate information—a key component of "rational understanding." Indeed, the evaluation of an individual's capacity to appreciate information is a fundamental and uncontroversial aspect of forensic mental-health assessment that can be readily performed by mental-health professionals.

Studies show that mental-health professionals using structured interviews and assessing present-oriented functional capacities typically show very high levels of agreement. *See, e.g.*, Gary B. Melton et al., *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* 148 (4th ed. 2017). The central feature of the mental-health professional's effort to assess an individual's mental functioning in relation to competency for execution is the clinical interview. The interview may begin with gen-

eral, factual questions such as: "Why are you in prison?" and "Why have you been sentenced to death?" After establishing the factual framework, the interviewer might then address the examinee's rational understanding with questions like: "Will you be executed?" and "What preparations have you made in anticipation of your execution?" *See, e.g.*, Patricia A. Zapf et al., *Assessment of Competency for Execution: Professional Guidelines and an Evaluation Checklist*, 21 Behav. Scis. & L. 103, 117-119 (2002). To the expert forensic psychologist or forensic psychiatrist, the answers to these questions reveal much about the subject's mental capacities, and if necessary follow-up questions can probe ambiguous replies. In addition, the clinician will consult collateral sources of information, including prison personnel, family members, and attorneys, as well as the individual's treatment records and mental-health history. Kirk Heilbrun, *Principles of Forensic Mental Health Assessment* 99-107 (2001); *see also* Mark A. Small & Randy K. Otto, *Evaluations of Competency to be Executed: Legal Contours and Implications for Assessment*, 18 Crim. Just. & Behav. 146, 154-155 (1991).

Mental-health professionals are also trained to assess an individual's everyday functional capacities, which amici submit a court should consider as part of its analysis of whether a prisoner is competent to be executed. Professionals must regularly assess older adults' ability to perform "instrumental activities of daily living," including managing finances, health, and functioning in the home and community. American Bar Ass'n Comm'n on Law and Aging, *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists* 25 (2008). There are standardized guidelines for assessing these abilities, through clinical interviews, observation, and where possible, collateral

reports. *Id.* at 25, 31-32. In making the assessment, clinicians may also employ a battery of cognitive tests for skills such as attention, language, and executive functioning, which may also affect an individual's functioning capacity. *Id.* at 39. An individual's inability to perform instrumental activities of daily living factors into the clinician's assessment of the person's other functional capacities, including testamentary capacity and capacity to consent to medical care. *See id.* at 16, 17. These capacities are relevant to an individual's competency to be executed; someone who lacks the ability to make medical decisions or draw up a will can hardly be said to be able to "fit himself" for death, *Ford*, 477 U.S. at 407.

Thus, through well-established procedures that tend to produce agreement among diagnosticians, mental-health experts can provide testimony that can meaningfully inform judicial decisions about competency to be executed.

C. Mental-Health Professionals Have Developed Valid And Reliable Methods To Identify Persons Feigning Impairment

Although both sides' experts concluded that Mr. Madison's dementia and associated symptoms were not feigned, an obvious concern with any capacity standard is that some prisoners will malinger, i.e., fake impairment, in an effort to be adjudicated incompetent to be executed. That concern is substantially mitigated, however, because psychologists, psychiatrists, and other mental-health professionals can employ a variety of techniques and tests to reliably identify people who are exaggerating or fabricating impaired emotional, behavioral, and/or cognitive impairments. *See Clinical As-*

sessment of Malingering and Deception (Richard Rogers & Scott D. Bender eds., 4th ed. 2010).

For example, in addition to the imaging tests discussed above, mental-health professionals evaluating prisoners consider factors like whether reported symptoms are consistent with what is known about genuine mental disorders and how they manifest, as well as the prisoner's presentation over time and across various contexts and situations (as documented in medical, mental-health, and correctional records). Furthermore, some psychological tests can aid in discriminating between prisoners who are and are not genuinely impaired. Some of these tests involve scales designed to identify examinees who are feigning impairments. *See, e.g.*, Personality Assessment Inventory; Minnesota Multiphasic Personality Inventory-2-RF. Other tests can identify persons exaggerating symptoms of psychosis or impaired cognitive functioning. *See* Structured Interview of Reported Symptoms-2; Miller Forensic Assessment of Symptoms Test; Word Memory Test; Test of Memory Malingering; Validity Indicator Profile. Put simply, although detecting every instance of malingering is impossible, expert examiners' ability to detect it is sufficiently strong that the risk of malingering should not preclude courts from considering everyday functional capacity in their assessment of rational understanding. As explained, applying that concept here leaves no doubt that Mr. Madison lacks a rational understanding, such that his execution would violate the Eighth Amendment.

CONCLUSION

The judgment of the Mobile County Circuit Court should be reversed.

Respectfully submitted.

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