IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT OF THE STATE FLORIDA, IN AND FOR PINELLAS COUNTY
CASE NO.: CRC23-03157CFANO

STATE OF FLORIDA,

Plaintiff,

vs.

THOMAS ISAIAH MOSLEY,

Defendant.

_____/

PROCEEDINGS: TESTIMONY OF
JOHN MATTHEW FABIAN, PSY.D., J.D., ABPP

BEFORE: THE HONORABLE SUSAN ST. JOHN
Circuit Court Judge

DATE: June 26, 2025

PLACE: Courtroom 2
Pinellas County Justice Center
14250 49th Street North
Clearwater, Florida 33762

REPORTED BY: Charlene M. Eannel, RPR
Court Reporter, Notary Public

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A-P-P-E-A-R-A-N-C-E-S

APPEARING ON BEHALF OF THE STATE OF FLORIDA:

COURTNEY SULLIVAN, ESQUIRE
CHRISTIE ELLIS, ESQUIRE
Assistant State Attorneys
Office of Bruce Bartlett, State Attorney
Pinellas County Justice Center
14250 - 49th Street North
Clearwater, Florida 33762

APPEARING ON BEHALF OF THE DEFENDANT, THOMAS MOSLEY:

MARGARET RUSSELL, ESQUIRE
JULIA B. SEIFER-SMITH, ESQUIRE
Assistant Public Defenders
Office of Sara B. Mollo, Public Defender
Pinellas County Justice Center
14250 - 49th Street North
Clearwater, Florida 33762

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P-R-O-C-E-E-D-I-N-G-S

THE COURT: Good afternoon, everybody. You can have a seat. I see Mr. Mosley is present already. We have a court reporter here. Okay.

We're here on Case Number 23-03157CF. State of Florida versus Thomas Mosley, and today is the first day of our competency evidentiary hearing, and the notes I have from our conversations previously is Dr. Fabian is going to be testifying today; is that accurate?

MS. RUSSELL: Yes, Your Honor.

THE COURT: All right. Is there anything we need to discuss before we get started with testimony?

MS. RUSSELL: Two matters, Your Honor. First of all, it's Margaret Russell and Julia Seifer-Smith on behalf of Mr. Mosley. Dr. Fabian is present and waiting in the gallery.

If I might approach?

THE COURT: Sure.

MS. RUSSELL: This is our motion filed this morning for the disclosure of Dr. Railey's score sheets for the WHODAS 2.0. We don't necessarily have to argue that much in today but eventually we are going to be wanting that in order to prepare for Dr. Railey's testimony two weeks from now.

THE COURT: Okay. I don't -- I don't want to do that today for a couple of reasons, and it's probably a good time to bring it up. We're a hard stop at 5:00 today.

MS. RUSSELL: Absolutely.

THE COURT: I don't know how much time you expect Dr. Fabian to take. I just want to make sure I give you enough time to get him done before 5:00, and then if we have time afterwards, I'm happy to discuss it, or we can discuss it on one of the other days.

MS. RUSSELL: Understood, and I appreciate the accommodation of starting early, Your Honor.

THE COURT: Okay.

MS. RUSSELL: The only other preliminary matter is may we have permission to conduct the direct exam from the table --

THE COURT: Of course.

MS. RUSSELL: We're using his PowerPoint, which because of technology problems, we're --

THE COURT: You all have a lot of paper and stuff. Wherever you are more comfortable is fine with me.

MS. RUSSELL: Excellent. Well, I think we are ready to go, and we are ready to call to the stand

Dr. John Matthew Fabian.

THE COURT: All right. Do you have any preliminary matters before we get started with Dr. Fabian?

MS. SULLIVAN: No, Your Honor.

THE COURT: All right. Let's have Dr. Fabian up here, please.

THE BAILIFF: Right up here for me, sir. Once you get over here, if you can face the clerk, raise your hand and accept the oath.

(Witness was duly sworn on oath.)

THE BAILIFF: Come over here. Have a seat. Make sure you answer in a loud and clear voice for the Court.

THE WITNESS: Sure.

MS. RUSSELL: For the record, thank you to Eric Ferguson from the IT Department of the Public Defender's Office who worked very hard to make this technology work.

DIRECT EXAMINATION

BY MS. RUSSELL:

Q. Hello, sir.

A. Hello.

Q. Would you introduce yourself to the Court, please?

A. Sure. My name is John Matthew Fabian.
Q. Dr. Fabian.
A. Yes.
Q. What is your career of choice?
A. I practice as a forensic psychologist and neuropsychologist.
Q. I would like to talk to you a little bit about both your educational and vocational background, but first I'm going to --
MS. RUSSELL: If I may approach, Your Honor?
THE COURT: Yes.
BY MS. RUSSELL:
Q. -- show you what's been premarked as Exhibit 1, which is your CV.
Dr. Fabian, is this your curriculum vitae?
A. Yes, it is.
MS. RUSSELL: May we ask that Dr. Fabian's CV be admitted into evidence as Exhibit 1?
THE COURT: Any objection to Exhibit 1?
MS. SULLIVAN: No objection.
THE COURT: It will be admitted as such.
(Defense Exhibit 1 was received into evidence.)
BY MS. RUSSELL:
Q. Dr. Fabian, tell me about your background.
A. So I'm from Ohio originally, and I've been a

psychologist in the forensic field for about 26 years, and I can go through that in a bit with, you know?

Q. Do you want me to change the slide, or can you change the slide?

A. I will do it. Okay.

So, basically, I have a bachelor's degree in political science and psychology from the University of Cincinnati. I have a master's degree in general psychology there. I have a master's degree in clinical psychology. And I have a doctorate in clinical psychology with an emphasis in forensic psychology from Chicago School of Professional Psychology.

I went to law school -- I've been a masochistic nature. I don't practice law, but I attended Cleveland Marshall and also Case Western's University of Psychiatry and Law programming there.

I then became -- I started studying neuropsychology, clinical neuropsychology, and earned a postdoctorate certification in clinical neuropsychology from the Fielding Graduate Institute, which then allowed me to get into fellowship training at the University of New Mexico School of Medicine in the Albuquerque, VA polytrauma unit in New Mexico working with veterans as well.

So that was a postdoctorate fellowship in

clinical neuropsychology.

Q. What did you do when you finished your postdoctorate?

A. Well, I continued my forensic practice in Ohio. Actually, I had returned there for a period before then moving to Austin, Texas, which is where I live primarily. I spend a lot of time in Florida as well, but I -- my whole career has been really working as a court psychologist and neuropsychologist, and I can kind of go through that career trajectory.

Q. Excellent. Tell us more about your career trajectory.

A. Yeah. So, I guess it started in Chicago. So I was at the Cook County Jail for a year. That's where really, I learned mental illness and was assessing, you know, folks. Back in Ohio, I also was exposed mostly to, you know, graduate training and education with my, you know, undergraduate and graduate degrees. I did an externship at the state hospital system, where it was a Not Guilty By Reason Of Insanity Ward.

Then I also was an aquatics instructor at a Fairfield Center, it was a residential treatment facility for intellectually disabled. I was a lifeguard. We had a lot of swimming aquatics programs at this facility.

But in Chicago, I was in graduate school and

that's where I learned more of mental illness, and then really how to conduct psychological testing, including intelligence. Then I did a year at the Federal Bureau of Prisons in downtown Chicago.

Then for internship, I went to the Medical College of Ohio. That was a residency program where I was the Court psychologist trainee, and that's where the rubber hit the road, where I was starting to do competency, insanity, sexual predator evaluations, mitigation, risk assessment, where I was assessing defendants for legal purposes, legal questions that the Courts or lawyers had.

Then I really started my career -- in Ohio, they have probably about 10 court psychiatric clinics around the state. They're either in regions or in large cities. So I was a director of one, and I had worked at four of them, three adult and one juvenile, and these were in pretrial, presentence capacities. Again, like competency, insanity, aid in sentencing for the Courts, risk assessments, and working closely with probation departments, assisting the Courts in sentencing folks.

I did that for several years and started working in capital litigation and mitigation probably in 2000, 2001. Then after several years, I moved to Minnesota and worked -- I would just say parallel like Florida State

Hospital of Minnesota. So it was a maximum-security state forensic hospital, and I was one of several forensic psychologists at that time, where it was pretrial evaluations, competency, sanity, mitigating circumstances, risk assessment, but also, they had a Jimmy Ryce law there. So sexual violent predator civil commitment, and mentally ill dangerous civil commitments. So I evaluated folks there.

That was the end of the road in that state. I mean, that was a maximum-security state hospital. So when I was in Ohio, I was doing, like, a court psychiatric clinic in a city, county, or region. In Minnesota, it was the whole state of Minnesota.

So I did that and realized that with the death penalty work I was doing, I was missing half the boat because a lot of these defendants had neuropsychological, neurological conditions, and I needed further training in order to do and understand those types of, you know, neuropathology, how the brain works, versus just psychopathology of mental illness.

So that's when I did a few years extra training in neuropsychology, and, you know, did fellowship training as well. And so I practice, essentially, as a forensic psychologist and neuropsychologist doing these evaluations.

Right now, I handle a lot of -- most of what I would do is still pretty much court-appointed. A lot of my triangle is Austin, San Antonio, and Houston and everywhere in between.

Then I do a fair amount of work here. I'm licensed in Florida. We have a -- we have a -- we -- I have a place we stay at in Hollywood as well, Hollywood Beach.

So that's pretty much kind of the trajectory of what I do, and most of what I do is pretrial, presentence evaluations for criminal courts with adults and juveniles.

Q. Do you have any Board certifications, Dr. Fabian?

A. Yes, I do. So I'm Board-certified --

Q. Dr. Fabian, maybe if you point it at the computer over here.

A. Oh, that's what I need to do. Okay. That computer.

Q. I got it up. Slide 3, right?

A. Yes. Forensic psychology, clinical psychology, fellowship training, clinical neuropsychology, those are Board certifications.

Q. Have you had any academic appointments?

A. Yes. So I don't have them on the slide. I was -- I taught two courses at Cleveland State University

in the Department of Psychology. One was Psychology of Violence. The other one was Forensic Psychology in the Law, and I did teach intellectual assessment at Case Western Reserve University Department of Psychology.

More recently, I've been doing forensic psychiatry and psychology, training the fellows at these institutions. Stanford University, I -- they have a forensic psychiatry fellowship, and yesterday -- so ironically, yesterday they said, Are we doing it again this year? Yes.

So I present on the death penalty and sexual violent predator civil commitment legislation and evaluations of sex offenders.

Then the University of Texas Health Sciences Center, they have a psychiatry residency fellowship I do didactics training with, which I also do at Walter Reed. They have a forensic psychology and psychiatry program which they focus only on forensic evaluations within the military criminal justice system. So I do -- well, I do presentations with them with their fellows to train them.

And then I -- I think the next one is -- let's see if I can do it. I think yours is working. Do you want to just do it?

Q. Sure.

A. Because I was pressing over there and --

Q. I think if you press and if you direct it toward me, it will work better. There we go. Yes.

A. Okay. This is basically what I said before just about the kind of career. I do quite a bit of pilot air traffic control evaluations as well, which -- for FAA. So just fitness for flight duty, psychological, psychiatric conditions, and neurological conditions.

They may -- a lot of it is ADHD, traumatic brain injury, other type of neurological conditions as well. Sometimes I will see strokes. Just other conditions where the FAA has been flagged to have further evaluations.

Q. Are you a member of any professional organizations?

A. Past and present, yeah. I mean, I think like American Psychology Law Society in the past. More recently, I've been a member of, like, National Academy of Neuropsychology, and I've been a member, I know, of ATSA for sex abuse, sex offender-type evaluations and assessment.

Q. Have you published any articles?

A. I have, yes.

Q. How many?

A. I don't know. I forgot. This is updated except -- I'm not boasting here, but I do -- I do have a book in press that's coming out August 1st, so that should

be on the top here, publications, which is from Wiley & Sons. It's not on there.

But as far as, you know, publication in my field based on kind of the evaluations that I do do, I am published in quite a few book chapters, journals. I don't know if you want to put any of them on the record or.

Q. Well, I think we have your CV.

A. Sure.

Q. But it looks like maybe 30 or so articles and peer-reviewed research?

A. That's fair. Yeah.

Q. Okay. How many cases have you been qualified as an expert?

A. Do you mean to testify, or just where I've gotten Court orders.

Q. To testify?

A. 600, maybe.

Q. And that's over the course of the past 20 years?

A. 26 years, yeah. And I -- the other thing I'll say is that, you know, some of them are civil and family law cases, but most of them would be criminal.

Q. And what jurisdictions have you been qualified in?

A. Probably 22 state and federal courts.

Q. All right.

Dr. Fabian, is it time to switch gears and talk about your testimony today?

A. Sure. I'm done talking about myself. Yeah.

So intellectual disability, I think that's kind of what we're here for, right? Okay.

Q. And is there anything else that you're going to cover today in your testimony?

A. Well, I think related to the topics intellectual disability, maybe in the lighter context of competency to stand trial, and also other psychiatric, neuropsychiatric conditions or diagnoses related to schizophrenia and Autism Spectrum Disorder, ASD.

Q. So tell me in all of your experience working with people with intellectual disability and understanding that condition, can you tell me why people with ID struggle in court cases?

A. Well, I look at it, when you look at cognitive ability and intelligence and you look at adaptive functioning, that covers much of human nature and how someone navigates their life. So they both are very important to the assessment of intellectual disability, but also just to how people function and get along and live and survive.

So when you're intellectually disabled, you have cognitive deficits, again, we'll talk about ability

intelligence, but there's typically significant impairments in not only cognitive ability and skills, but emotional functioning, behavioral functioning, interpersonal functioning, and -- yeah, I mean, social functioning.

You know, unfortunately, they're less resilient than the typical person, and they're more prone to experience other neurological conditions, other psychiatric conditions and diagnoses and, you know, they're just more susceptible to a lot of other impairments and conditions.

Q. Okay. Has the Supreme Court in the United States written about some of these problems?

A. They have.

Q. Okay.

A. And the case I have evaluated just got granted cert June 6th, and they are hearing a case on cumulative IQ scores. And that's Hamm, H-A-M-M, v. Smith. So they have heard on Atkins -- was it Texas v. Moore, Florida v. Hall, so a litany of cases that are addressing similar but distinct issues.

Q. Should I switch the slide, and you could tell us about Atkins?

A. Yes.

Q. Okay.

A. So the -- yeah, the U.S. Supreme Court, I have a law degree, I don't practice, but I can briefly comment on this. You know, the U.S. Supreme Court found it was in violation of the Eighth Amendment, it was cruel and unusual to execute and put to death someone who qualified as intellectually disabled.

And, in part, because I think the frailties of that population and issues related to retribution, deterrence, you know, do they appreciate, you know, their punishment, issues of that nature.

Q. Okay.

THE COURT: Am I going to get a copy of the PowerPoint at some point?

MS. RUSSELL: Yes, Your Honor. Do you want a copy now?

THE COURT: I would love that.

MS. RUSSELL: Oh, okay.

May I approach?

THE COURT: Yes. I'm not always at the best angle for seeing the screen.

MS. RUSSELL: I apologize. This is Number 2.

THE COURT: Do you want us to put this in now?

MS. RUSSELL: Sure, if there's no objection.

THE COURT: Is there any objection to it?

MS. SULLIVAN: No.

THE COURT: It will be admitted.

(Defense Exhibit No. 2 was admitted.)

BY MS. RUSSELL:

Q. So moving on to Moore v. Texas?

A. So Moore vs. Texas, I can get a little specific, but the State of Texas identified by case law the Briseno factors, and much of that adaptive functioning was based on the defendant's role in the crime, their homicidal behaviors.

And the U.S. Supreme Court was looking at the nonclinical judicially developed means of diagnosing intellectual disability, ID, including the defendant's role in the crime, and those Briseno factors that were basically adaptive functioning related to the offending behaviors.

And they emphasized -- the Court emphasized the clinical assessment of intellectual disability and the professional assessment of it, focusing and referencing on the American Association of Intellectual and Developmental Disabilities, and the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

So for short for this hearing, AAIDD and APA or DSM. And the Court focused that, you know, modern scientific clinical standards, really referenced by those two organizations, is how intellectual disability should

be evaluated, and we'll cover that today, but that was the main thrust of that holding.

But also, you know, that an individual with ID can also have other disorders such as, you know, antisocial personality disorder, personality disorders or other, you know, mental illness. They can have, as we say, co-morbidity, other psychiatric conditions, along with the ID condition.

Q. So Moore tells all of us that intellectual disability, in a legal context, should be governed by a scientific consensus; is that fair?

A. That is very fair, yes.

Q. So what are some of the features of individuals with intellectual disability that cause problems in the criminal legal system?

A. Sure. In that -- I didn't fully answer your question before about, you know, why they struggle in the criminal justice system, and this, I think, slide can help answer that question.

So the characteristic feature on the left is very helpful because that gets at some features of ID, but also overlaps with adaptive functioning and neuro-cognitive deficits that we often see part and parcel to cognitive ability or what we call intelligence.

So characteristics such as gullibility, naivete,

acquiescence, desire to please. Now, those, when I do competency, you know, to waive Miranda rights or confession type of evaluations, certainly are relevant in those types of cases. When a defendant may be given their rights or a choice to make a statement or leave, and more of an interpersonal part -- a social part of adaptive function that we'll go over.

Now, the other ones get into concrete thinking, memory, attention, language. So receptive and expressive language skills. Those are, you know, key in communication, which folks with ID often struggle with.

They may not be neuropsychological tests that are exactly listed in an IQ test, but they're relevant to the proper neuropsychological assessment of intellectual disability where we really will always do an IQ test, but there's other cognitive neuropsychological tests that are relevant in -- with assessing this population.

So these language deficits are relevant to how they understand language at different levels of the criminal justice system, such as during, you know, interrogation where their ability to communicate their thoughts, feelings even to lawyers in competency to stand trial related legal matters.

The memory, obviously, is critical in a number of forensic assessments where we're looking at their

ability to attend to information, present it either on paper or verbally, as well as their ability to manipulate that information in mind, which is really working memory, which goes from attention to memory. Working memory is kind of somewhere in between. Processing that information, and then learning -- remembering it, recalling it.

So that neuro-cognitive skill set is quite important to competency proceedings whether it's Miranda or competency to stand trial. We'll probably get into that in a bit.

Then also, you know, their ability to, I guess, display appropriate emotions pursuant to the nature and context of what's going on. You know, are they emotionally appropriate given the matter at hand? And sometimes they may have what we call maladaptive behaviors, where they can show aggression, anger, impulsivity where a typical person will not.

Finally, the last one is cloak of competence which is really an important concept in these types of cases and evaluations in forensic criminal justice matters. And that's really a lot of individuals that have ID don't want to have that label.

In that case, I'm referencing Hamm v. Smith. That gentleman -- you know, a lot of these folks have been

abused, ridiculed, picked on their whole life about being slow, being quote, retard, end quote, and it's always had a negative connotation, that label.

So they often will present as they understand what people are saying when they don't because they don't want to look, you know, ignorant, unintelligent. They don't want to be picked on, rejected. So they will cloak and cover competence and yeasay and answer yes, and say they understand when they really don't because they want to fit in and, you know, look the part like they're intelligent.

Q. How do those factors influence the Florida standards for competency?

A. Sure. So there are, I would say, no matter what jurisdiction, including Florida, there's going to be cognitive comprehension versus appreciation and rational reasoning and logical thinking. Essentially, the types of prongs or elements that are going to be relevant to a defendant's, what I refer to as, psycho-legal abilities.

So do they understand the charges or allegations? That's, you know, a comprehension, cognitive, knowing understanding. And I look at that as, in part, like, Do they -- do they understand the charge, the elements, the severity, the consequences if convicted? But then do they appreciate issues related to their case?

So it's not just understanding and cognitive kind of knowing, it's an appreciation as well.

So there's an abstract reasoning component of this. Certainly, understanding there's two sides. That they're adversarial. I know this is basically narrative testimony. I don't know if it's appropriate, I can present examples.

Q. Sure.

A. Okay. The other night we had, basically, a rape -- a life rape case where the defendant had both autism and intellectual disability where they reported a 58 -- a 58 IQ score, and it was hard for him to appreciate that the prosecutor was not there to help him. And over the course of the evaluation, it was difficult for him to appreciate -- actually, understand, appreciate, and retain terms and information.

And over time, over a couple of hours, he could not demonstrate that fully. He understands some information, but he was able to parrot some of that information back, but not fully appreciated pursuant to his fact pattern.

So you could understand words, but can you apply it to your case? And he failed doing that with my evaluation. Whether he's restorable, I'm not clear, but that would be an example. They have to understand,

comprehend, but apply it to their case. And that is information, but then they have to make legal decisions, which is even more of a higher-order, I think, cognitive skill set.

So when we're looking, some of these, you know, these several six factors understanding, disclosing. D would be related to communicating, and facts of their case.

E is more, can they control themselves emotionally, behaviorally? Do they understand, comprehend, and appreciate courtroom conduct? Testify relevantly, it's going to be, again, communication skills fluency, but also understanding, which we get into more, like, oral language, auditory, comprehension skills. Your questions, and to be able to answer them rationally on point.

Going back to A and B, you know, this is more about understanding, comprehending legal terms. I think that the next slide gets more complicated, as far as cognitive demands.

Q. So how should an expert begin to think about the problem of competency with ID?

A. Competency to stand trial evaluations, they take work for the examiner when -- it's often -- even with some intellectually disabled folks, they may be able to

understand and comprehend words, okay? Defense lawyer. The other night the gentleman said they're there to help me. He's right.

They may understand what a jury does. Where the meat and the complexity is, is how are you going to handle your case, and you need to make legal decisions. That becomes more difficult for them, and it takes a lot more work for the expert to examine. And that's where experts, they -- some of them don't put enough time into that part of the evaluation.

So when we're looking at, like, this slide, the sufficient present ability to consult with counsel, and the reasonable degree of rational understanding. And so applying the facts to the legal decisions and options that the defendant has, and to communicate that with trial counsel, that's -- there's a lot of meat there to evaluate.

So "rational" means a reason. Is it logical pursuant to your own fact pattern? And we'll get to trial demands in a minute because that's more pressing cognitive demands on a lower-functioning individual.

Q. All right. So what are the psycho-legal skill sets that are required for a defendant to engage in a death penalty trial?

A. Well, we start, you know, again, with the easy

prong, so to speak, of understanding -- you know, do they understand their charges? Legal concepts is going to be, you know, broad. That can be charges and pleas. You know, do they understand the elements of the offense?

They do not, as you know, need to be a lawyer, okay, but they need to have sufficient ability to understand really the nature of the charge, the elements or offending behaviors that are relevant to that charge. They ideally will have recollection. We call more of that declarative autobiographical memory of what happened.

Ideally, one -- you know, a lack of memory or amnesia is typically not a bar to competency, but it does compromise the communication that you, as a lawyer, would have with your client.

So comprehension of police version of events, but also -- you know that could include where you've given Miranda rights, did they ask you if you're free to leave? A lot of defendants don't remember or don't know, or they can fabulate, which is a true lie, meaning, they don't know, and they may say they do know, and they say, Yeah, I was read my rights when we know they weren't.

So now the -- when -- you know, when I do these evaluations of competency, and I do them multiple times a week, you know, I do ask them what happened and I don't document that, unless they are competent and there's an

insanity referral with it, but I want to know if they can testify to what the facts are in their case.

Also, you know, how they respond to my questions and to get an understanding as to maybe even a brief testimony style or ability or capacity. So those are -- and, again, when we're dealing with someone that we suspect or know is ID, we're going to want to look at this cloak of competency because they may say they understand legal terms, but that does not mean you assume they do. You then need to take a step further and say, What does that mean?

The last bold I find, you know, to be a significant factor here in these types of cases. The trial demands of cases are relevant. You know, is it possible that an individual, let's say, who is ID is competent, you know, cocaine possession case and not in a death penalty case? Yes, that's possible.

Q. Why would that be?

A. The cocaine case may take a day of trial. The facts may be a four-page police report. It may not be weeks of jury selection, weeks of a jury trial, a death penalty mitigation phase. The cognitive demands are much less significant, let's say, in misdemeanors or other types of felony cases.

Q. Okay.

A. You're asking a defendant to attend, concentrate, assimilate, process, recall, retain information and assist you in hours or a day versus weeks or months.

Q. Is it just about the time, or is it also about the complexity?

A. Both.

Q. What else, Dr. Fabian?

A. Well, some of this seems simplistic, but it's not where individuals may understand the severity of the charges, but they may not really appreciate the consequences, the here and now.

Often similar to dealing with, let's say, a juvenile or a child or adolescence, where it's difficult for them to have a future orientation perspective.

And the understanding and recollection of pleas and alternative pleas. Now, the no contest and not guilty by reason of insanity pleas or, in some cases, diminished capacity or even self-defense, these are very complicated. More of those versus just I'm guilty or not guilty.

So with folks with ID, I often see that we have a problem after not guilty. So when we go to no contest or NGRI, it is difficult for them to understand and appreciate, but when I say "understand," that means, let's say, I'm mentally ill or mentally defective and did not

know what I was doing.

So that does require -- they may understand that on its face, but then you appreciate -- understand and appreciate that you are defected -- defective or you have a mental illness or intellectual disability. How that may apply to your offending behaviors and how that can be appreciated as a legal safeguard in your case. So that -- there's a lot of depth to that.

And the other area that's complicated which, you know, requires abstract thought is: Do you understand what a plea bargain is? Often the answer is no, and we go into my typical example of a flea market. Trade. What would you like? Air Jordans. I like video games. I have a booth. You have a booth. We're at a parking lot. I trade this. You want that. You've got to give something up to get something. And what are the rights that you give up if you take a deal? That is complicated.

Do all experts ask that? No. Should they? Certainly. So the level of abstract reasoning gets deeper as you peel the onion. Like, you know what a deal is? A trade. Then we want to kind of keep -- what about your case? What rights do you give up? Can you testify if you take a deal?

Or simple questions, if you take a plea bargain -- or if you plead guilty, can you go to trial?

Okay. So you're not putting that not guilty in there. You're mixing it up. If you plead guilty, can you go to trial? And that simplicity is very much a concern in these types of cases, which is kind of (indiscernible) in a plea bargain process.

Now, the parroting -- and there's case law on this, but capacity to understand legal advice. We're limited when we do these evaluations, and I will highlight that. It depends on who refers us, how we're resourced. We're hired by JAC versus the Public Defender's Offices, whatever.

It's difficult to assess how long that defendant can retain this information. So can they parrot it for, you know, sometimes the 40 minutes the evaluator is there? And then 40 minutes later say, What did I -- what was a plea bargain?

I did that the other night, but it was a couple hours, and he could not retain that information. And so the parroting will say later on, Do you remember I asked you what a plea bargain is? Maybe they say "deal," but I want to ask them again, How would you apply that to your case? What are you going to do with your case?

So it's not just deal and parroting that information back. It's, like, you need to apply it to your own case. That's where -- that's another area of

abstract reasoning. So then that's when how are you going to rationally assist your attorney in planning legal strategy?

Now, we can have debates as to who makes what decisions in court. Obviously, the defendant has a right to testify, but the legal strategy, you know, the defendant should have some input. Whether that lawyer takes it their own direction, you know, but they need to be able to assist their counsel in planning legal strategy or appreciating the rational decisions of taking a case to trial versus taking a plea, for example.

Q. And that requires abstract reasoning?

A. Yes. And the last one -- yeah, the last one is: Do they have realistic and plausible appreciation as to really the outcome of their court case? And that is -- that gets a bit deep as well. Appreciation and now there's other factors of denial, you know, but folks that have cognitive limitations may not have a realistic appraisal as to the consequences.

In some cases that I've had, you know, let's say the parents are heavily involved and whenever you're in court, they look at mom and dad to answer the question for the lawyer, even as an adult, low functioning, and the parents have always taken care of them, and so they may not have a realistic appreciation as to the consequences.

Q. Anything else, Dr. Fabian?

A. No.

Q. All right. Let's switch gears and talk about intellectual disability and diagnosis.

What is "intellectual disability"?

A. Oh. Can you go back to 15?

Q. Sure.

A. Just two I want to mention. The capacity to track events and follow, process, and recall information. That is often markedly impaired with low-functioning or ID folks. I -- I don't see that as the only issue where a person is found not competent. Whether that could be, sure. I often don't see that as being the decision because usually there's the Dusky standard involved as to rational reason, which is different than cognitive attending, processing, and recollecting.

So if we really looked at that bullet point, in my experience, most ID folks will fail on that. There's no way they can comprehend and attend to recall information for months.

The other one is challenge witness testimony. And that's you, at the trial table, have the -- your client, the defendant, assisting that trial counsel in the here and now that day and time at that trial table when someone is testifying.

And their ability to, you know, understand, comprehend day and time, that information and assist trial counsel is another area that is often impaired, and that's difficult to assess in an evaluation. What you do is you read them police reports and get into the facts of their case, and that could be certainly time consuming.

Q. Especially in a courtroom scenario where things aren't repeated and things happen quickly --

A. Right.

Q. -- it would be difficult for someone who is disabled to necessarily engage and respond appropriately; is that fair?

A. Fair. In very complicated cases, I will meet with the defendant and lawyer or lawyers together and do that evaluation.

Q. Anything else on that slide?

A. No.

Q. Okay. So now we'll switch gears and talk about intellectual disability and diagnosis.

So what is "intellectual disability"?

A. So, basically, it's a neuro-developmental disorder and it's a mental condition where the person has accommodation of cognitive ability, intellectual functioning deficits and co-occurring adaptive functioning deficits. You know, adaptive functioning is really how we

adapt, survive, and get along in our society, and we'll go through that.

So the AAIDD I would say is the leading organization that defines and conducts research both with the assessment and even the determining needs and supports and providing information to society and the community as to intellectual disability.

The three prongs are: Significant or substantial limitations in intellectual functioning, substantial limitations in adaptive functioning, and then onset before -- or during the developmental period. In the last 5 years it's been extended from age 18 to age 22.

Meaning two things: One, it's a neuro-developmental mental disorder. Developmental -- a compromise in brain development during the developmental years, and the reason, in part, that they extended it was just what we know about neuroscience and brain development.

Q. In young adults, correct?

A. Yes.

Q. So that's sort of the Miller and Graham aspect of pushing forward --

A. Yes.

Q. -- brain development in juvenile law?

A. Correct.

Q. Okay. And the two organizations that do diagnostic --

A. Yeah, the other --

Q. -- information is what?

A. Yes. The AAIDD, that's the American Association on Intellectual and Developmental Disabilities. Then the APA, American Psychiatric Association.

Q. Let's start with the AAIDD.

What is it?

A. Yes. The American Association on Intellectual and Developmental Disabilities. And that, per your slide, has been around for 100 years, 150 years. They, again, produce guidelines and really the definition and assessment and diagnosis of that condition.

It certainly has developed over the years. They do publish a book. It's in its 12th Edition. You may have it. I have it on my laptop here. Thank you.

MS. RUSSELL: Yeah. We have a copy, if Your Honor is interested.

THE WITNESS: Yeah. And I appreciate the way it's written. It's not this big. It probably could be, and it's very easy and elementary to follow.

BY MS. RUSSELL:

Q. So what does the AAIDD say about intellectual disability and how it's defined?

A. Yes. So, again, significant limitations in both, and that's current in both intellectual functioning, adaptive behavior, adaptive functioning originating during the developmental period, essentially, prior to age 22.

Q. Is there anything else to it?

A. Yes. So they have assumptions, you know. There would be a lot else to it. We want to look at cultural issues, you know, where the person may be living. Community, contextual, I would say, elements. Language issues.

I had a case recently in Volusia County in Daytona where the defendant was born in Haiti, so there's language issues that you're evaluating.

So number two would be, you know, consideration of different other factors. Communication, sensory, perceptual motor, behavioral factors.

And three is quite important. You know, basically, the limitations, deficits that -- you know, these two organizations focus on limitations, significant limitations, substantial limitations, and acknowledging that everyone has strengths, but the more impaired, obviously, the less strengths a person has.

So when I was, you know, a lifeguard aquatics instructor for a residential treatment facility, that's where, you know, my hair was blown back with what ID was.

Q. What happened?

A. Well, what happened is you got to watch the people that you're instructing in the pool, okay? So we would have a few of us lifeguard instructors and if you have someone that's profoundly intellectually disabled in an inner tube and you're not watching them, you look over and they're underwater drowning and they do not have the capacity to do one thing, lift their head up and breathe and survive.

So I had never been around a profound ID person. 85 percent of ID folks are mild, thank heaven, you know. We go moderate, and I would say that's 85 down to 10 percent. Severe, probably 3 percent. Profound, 1 percent. So most of them are mild and we may not know that they're even mild, you know. So they're high functioning, of course.

Or we went to -- was it Ponderosa? And I did not realize that they -- certain more profound, severe folks, let's say, profounds really could not go on trips, but they would drink enough Pepsi to fill this room and not stop. So they have difficulties even with kind of bodily functions, and I was not aware of that.

Then I started when there were, you know, lightning, we couldn't do the swimming pool. We couldn't move folks across the facility because it was a whole

campus. So if we couldn't do training in the pool, we would go to residential. We would go to the units and help them, help the staff. That's where we were helping bathe, you know, and that type of thing.

So you would see the milds versus the profounds and kind of the levels of adaptive functioning even on their structured unit.

Q. And you began to realize that there are stereotypes in ID that maybe many people might think that the people drowning in the pool is what ID looks like? Like 85 percent of people have mild ID?

A. Yes. Yeah. I mean, eventually, when I was doing more evaluations for the courts, I would be -- you know, I may have somebody that I would be talking to interviewing, spent hours, even a day or so, and then go and do an IQ test and it would be a 72. And I would be like, no way his -- he -- I would be shocked, maybe, that their -- I thought their IQ would be higher, you know?

So just saying, Oh, I think based on interview -- their verbal skills during my interview, what their IQ would be, I don't do that because I don't know unless I do the testing.

Number four is -- yeah, four. So the AAIDD and the APA, I want to emphasize for the Court that this is really based clinical, you know, psychiatric, designed to

assess intellectual disability and really focusing on needs, supports, resources.

So you want to see how they function, IQ, intelligence, just as important to the adaptive functioning, to then get at, okay, how do we help this person, you know, adapt better in their context and society?

The death penalty is, like, separate. That's gotten important over the years, but I think that we sometimes lose the definition of really what this is. It's clinical and, you know, supports in the community to assist these folks.

Q. And what about the context of community environments in assessing ID? I'm not sure if we covered number one.

A. Oh. Yeah. Where are they going to live in the community? So, like, one of the instruments I may use in some of these cases, they'll have norms on folks that are ID, independent living, versus, you know, they need assisted living versus residential based on their impairments.

So, you know, there's a lot of different types of community services, resources, but also placements based on their deficits that we, you know, that they need to assess because, you know, everyone is going to have

different resources and live in different places in the community.

Q. What is "intellectual functioning"?

A. Well, traditionally we were focusing a lot on IQ, which we still do, intelligence and intelligence testing. In the last several years, both organizations, I think, broadened their definitions a bit qualitatively to, as we see, reasoning, planning, solving problems, abstract thinking, higher order cognitive functioning, learning quickly, efficiently, learning from experience, that bullet point is really executive functioning as a neuropsychologist.

So when I see that bullet point, that means that I should be evaluating their neuropsychological functioning with executive functioning, in addition to an IQ test.

The last -- go back, if you can.

Q. Go back.

A. Yeah. The last one, traditionally, we have in a slide here in a minute, you know, when we're looking at a bell curve. You know, the average Joe is 100. A standard score is 70 will be two standard deviations from that second percentile, give or take. So, you know, that basically 70 to 75, and depending on the state, jurisdiction, court, you know, it's around the score of

70.

The AAIDD in the DSM have written that, well, 75 because we're considering, you know, it's a standard measurement.

Q. So that feels like it's the next slide.

A. Yeah. So that --

Q. Significant limitations. What are significant limitations in intellectual functioning?

A. Technically, they do have an objective finding that they still adhere to both organizations, where it will be two standard deviations below the average score of 100, and that would be a 70. That just means 98 out of 100 people that are the same age will score higher on that IQ test.

Q. So what are some examples of these limitations in intellectual functioning?

A. So -- and this is from the AAIDD Manual, 12th Edition, where the functioning area there's some examples, and we had seen that in the previous slide. Thinking and learning will be understanding complex ideas, abstract thinking, learning, processing information.

Reasoning and decision making. And that's -- will get into planning, initiating, putting forth your decision-making. And then flexibility and thinking. So cognitive flexibility.

Then finally, learning from experience. You know, kind of understanding consequences as well. Appreciating high-risk situations. Then how that may be affected by more of these emotional cognitive constructs of like gullibility, suggestibility.

Q. Let's talk about adaptive behavior, Dr. Fabian.

A. Sure.

Q. What is "adaptive behavior"?

A. Well, it's really how we adapt to our environment. Survive. Get along. Navigate the world.

The AAIDD and DSM break it down into three prongs of conceptual, practical, and social skills. So conceptual skills are concepts. So they understand concepts, like money. Can they read and write. Can they tell time. You know, mathematics. You know, can they kind of make decisions based on that type of knowledge.

The social skills gets really into kind of emotional, social, interpersonal. But social responsibilities, self-esteem, communication. It gets back to this naivete, suggestibility. Follower or leader. Are they able to follow rules, laws. The victimization. Are they taken advantage of?

And then practical skills focus, you know, really on getting around working, using, you know, public transportation. Following rules at work, use of money,

getting to the doctor. Those types of practical living skills.

And there's different ways that we'll see that we can assess adaptive behavior and in both -- especially AAIDD will offer, like, best practices.

Q. So tell us more about the AAIDD and how adaptive behavior is assessed.

A. So the best way to assess this, I think, what the AAIDD and APA empathizes to ultimately gather information about this person's adaptive functioning and that's records, collateral information, but also, at some point, have a credible knowledgeable, adaptive informant.

Be interviewed with a specific adaptive functioning test that is normed on different, like, populations ID and normal folks, so to speak. And to have that person or people rate that person's functioning here and now or in the past retrospectively. And there's some instruments that we may brush on that basically have, like, a 0, 1, 2, 3 scale.

A zero, the person can never do it.

1, they have difficulties. They may need assistance.

2, they're able to do it, but not always.

3, they can do it without a problem, like independently.

Q. So adaptive behavior is based on typical performance, not maximum or one-time performance; is that fair?

A. That is fair, but again, you can assess the examinee, patient, defendant, whoever, adaptively, which I do, but also interview one or more people that know that person very well that can answer those questions.

So when I have that form and I'm, you know, talking to the parent, if they cannot answer those questions, then I don't do a form.

Q. That's fair.

What about assessment in community settings?

A. Well, the community settings, you know, you also -- the context of where they're going to be placed is important. So I can, I guess, answer that question in a couple different ways. I mean, we want to know where -- the options they may be placed, where they may live, but, at the end of the day, we have to get someone that has knowledge and sometimes it may be at a facility that they've lived at that we may want to interview them about adaptive functioning of that individual.

Q. All right. Let's talk about the conceptual adaptive skill domain. I think that we've been through it a little bit.

Is there anything that we missed?

A. Okay. Well, if you go back to 24. Sorry. I'll keep on the same slide you are, so I don't break my neck.

If you go back to 24 and you're on -- you're looking at like, D, is your -- your assessment is based on the individual's typical performance at home, school, work, and leisure, not their maximum performance you had mentioned, but these instruments get into ratings as to different context. Let's say using the microwave versus using a bus versus going to a movie, let's say.

The community setting is going to be typical for that age peer. So we're assessing and rating an individual who the age ranges go probably from 18 to, let's say, 80 on these scales, and we're using their normative group that's the same age of that person you're evaluating.

And, again, ultimately, this information will provide data as to what supports they may need in the community.

So conceptual --

Q. Tell us about conceptual adaptive skills. What's in that domain?

A. Sure. So, again, it's about assessing concepts of their ability to understand concepts. This also gets into problem solving, planning, thinking abstractly, academics.

The second to last one is when we do these evaluations, we want to do reading, writing, math, these are achievement tests, okay? So typically, when someone is ID, they're going to have an IQ assessing cognitive ability around that 70 mark, but they usually have their academic achievement scores somewhere around that as well. They may -- they may be deficient. They may be higher than 70, but they're often around that mark.

So it's important to assess those academic achievement skills, which is one area of conceptual adaptive functioning. And a psychologist, a neuropsychologist will do that.

And then, you know, get information as to, you know, money cards, banking, how their money was transitioned from their employer to, you know, their -- either their bank account, but getting information as to that.

Now, I also have, I would say, neuropsychological adaptive functioning tests that can get into writing checks and writing letters, using maps. Those are hands-on adaptive functioning assessments that we can do. The field needs to progress with some of that, though, you know, as far as writing checks and whatnot as society changes.

But here, you're looking at concepts, money

concepts, using calculators, for example, things, you know, of that nature. Planning activities, which gets into a bit of the social prong.

Q. All right. Tell us about the social adaptive skills domain?

A. So that gets into the, you know, interpersonal peer relationships, who do they associate with, what do they do for leisure. Do they just do things by themselves. Social judgment. Appreciating, let's say, situations. Hazards of people they're associating with.

Then more of this cloak of competence, pleasing other people, gullibility, suggestibility. Then looking at vulnerability, victimization, and that can be relevant in different domains of their life.

Q. How about the practical adaptive skills domain.

A. That is more of, like, working, and kind of overlaps a bit with concepts with, you know, paying bills, writing checks, signing leases, purchases, credit cards. Then also, you know, hygiene, grooming, washing clothes, cooking, practical life skills.

Q. Does the AAIDD say that you need deficits in all three domains for a diagnosis of intellectual disability?

A. No.

Q. What does it say?

A. It says you need at least domain -- or deficits

in one or more domains.

Q. Tell us about the age of onset according to the AAIDD?

A. So that would be before the age of 22. And, again, that highlights that intellectual disability is a neuro-developmental disorder that should be, you know, that manifests during the developmental years. Whether it's formally diagnosed, that often is not the case.

Q. What are neuro-developmental disorders?

A. So, yeah. They are basically conditions listed in the DSM. The DSM, the APA will focus on several ID, intellectual disability; ASD, Autism Spectrum Disorder; ADHD, Attention Deficit Hyperactivity Disorder; LD, Learning Disorder, and then there's other ones that get into communication and language disorders, for example.

And it's really based on compromise in brain development, I would say, structure and function, but also that focus on processing of information. That is a hallmark of neuro-developmental disorders of any type.

With ASD, it's mostly emotional disability. With ID, it's cognitive and adaptive disability.

Q. So are some deficits that you might see in autism very similar to deficits that you might see with ID?

A. Yes. And I -- there's -- there's -- well, ASD

is -- has been more in the mainstream. You know, mainstream, I think in society, just a lot of talk about Autism Spectrum Disorder. And the prevalence is higher right now, and that's part of the reason why there's more discussion as to it.

When someone is intellectually disabled, they typically are so compromised that they have emotional, cognitive behavior, behavioral and social deficits. Folks with autism really have often that emotional, social impairment.

When we look at someone who was ID, we typically focus on the ID assessment, forgetting that a substantial amount of folks with ID qualify for ASD.

Q. We'll get to ASD in a little bit more detail down the road, but for now, tell me what the DSM-TR says about neuro-developmental disorders.

A. Sure. There's conditions that occurred during the developmental years, often prior to school, and they impact one's brain processing, functioning, and, again, produce problems, deficits, impairments a number of areas of life functioning: Academic, occupational, emotional, personal, social, behavioral, you know, domains.

They also can limit learning and compromise executive functioning as well as social skills. So that's when I do these types of assessments, as a

neuropsychologist, I do want to typically hit and assess all of those areas that are listed here.

Q. Why is it important to have a clear understanding of ID?

A. Well, I mean, diagnostic clarity is good. So sometimes because we just, like, the State statutes or requirements for disability, and to also figure out what supports and resources the individual needs.

Q. What are some of the limitations of people with intellectual disability?

A. Well, yeah. This may be redundant, Your Honor, but, you know, basically, impairments, intellectual functioning, adaptive functioning, and again, this really gets even into the neuropsychological functioning domain of executive functioning, problem solving, reasoning, decision making, and emotional and social functioning.

Q. So do people with intellectual disability have strengths?

A. Yes. I mean, obviously, the mild type will have the most strengths. So when we get to the profound, we really don't see many at all. But the folks that have the mild, moderate levels certainly have strengths depending on the individual.

Q. So could someone with mild ID send a simple e-mail?

A. Yes.

Q. Could someone with mild ID converse with their family?

A. Yes.

Q. Could someone with mild ID read a simple Bible passage like the 23rd Psalm?

A. Yeah.

Q. Could someone with mild ID learn to drive, albeit poorly?

A. Absolutely.

Q. Can someone with mild ID use a cell phone?

A. Yes.

Q. Why do we consider intellectual functioning beyond IQ?

A. Well, IQ is, you know, like, when I do an IQ test, it assesses a number of domains, but it does not assess every type of domain. And it's also limited as to, perhaps, the applicability to real-life situations. I think it's important to have an objective marker, as both organizations do, but we also want to look at just human functioning beyond an IQ test itself.

And then some of these other areas of functioning, again, problem solving, planning, initiation, decision making, interpersonal relationships, they are very applicable to everyday life, where the IQ may have

correlations with those, but they don't -- it doesn't measure exactly those factors.

So when we're doing these assessments, we're looking at data, you know, let's say from school records 30 years ago, about how they got along with kids. It's maybe not just about a score, or how they're doing now, whether they can, you know, do particular tasks. That may not just be related to a score.

So the organizations that really emphasize the last 10-plus years to equal the import for both adaptive functioning and intelligence. You know, an attorney the other day called me and say, Hey, what's her IQ score? And I'm like, It's not just that, you know. And it was in light of an Atkins question, but I'm, like, that's half the story; do you know what I mean? So we focus on the IQ score a lot.

Q. And the focus is also on adaptive behavior during the developmental period; is that fair?

A. Correct, and that is more difficult, at times, to assess. It's retrospective. You've got different informants. You know, it's based in part on the memory of those folks.

Q. And why is adaptive behavior an important concept?

A. Well, again, it's really that's how we navigate

the world, and how we get along with folks. So that IQ score is critical. And there's a correlation between IQ and adaptive functioning, intelligence and adaptive functioning, but this gets more into how you live your life.

Q. Is there anything else you wanted to say about the relationship between intellectual functioning and adaptive behavior?

A. Well, on 2 on this slide, it says a low to moderate statistical correlation between intelligence and adaptive behavior scores. And there's no empirical evidence to support a causal interpretation between the two.

So but it is correlational. You need both -- you need deficits, substantial deficits, of both domains intelligence and adaptive functioning to qualify for ID, but that does not mean you're going to -- typically, you don't have a 70 IQ, and then mom's adaptive behavior rating is a 70, you know, but they're often -- usually, there's, you know, limitations in both.

Q. Have you ever examined someone with a 55 IQ who had no deficits in adaptive functioning?

A. No.

Q. Why is that?

A. They're, like, at that point 1.55 percentile of

intelligence. So out of 1,000 people, 995 people will have a higher IQ score, and they don't have significant limitations in navigating their world. I've never seen it.

Q. Okay. One more time. I think we've covered the diagnosis of intellectual disability.

A. Yes. Do you want me to define it again?

Q. No.

A. Okay.

Q. So let's talk about best practices for assessing intellectual disability.

A. Okay.

Q. What are the best practices for assessing intellectual disability?

A. Well, we want -- we want, basically, to have as many records as we can about this individual. There are data points, obviously, school records, mental health records, work records, just for example. And then we also will want to utilize updated, appropriate, accepted assessment measures for intelligence IQ and for adaptive functioning.

So ultimately, you know, we're going to want to evaluate with ideally an informed collateral informant. So someone who knows this individual quite well and how they function and get along in society, in order to be

able to answer these questions on a required test.

So, you know, when I do competency evaluations on a robbery and the person may be low functioning, we may not have the resources to do all of this, but on an Atkins claim, we do. So, ultimately, you're going to need to have an IQ test and really academic achievement testing, as well as an adaptive test ideally, the latter with a collateral informant knowledgeable about this individual.

That may be easier to do with a pretrial case like this versus if that individual had been on death row for 30 years, and then we have to go back in time and then try to find people, for example, but also, too, I think it's -- I try to evaluate -- I'm seeing someone in Dallas this Saturday on an ID case, and I need to do some neuropsychological assessment with that person separate from IQ.

Some of that assessment is going to be as to practical adaptive functioning one on one. I'll interview them about, Hey, you ever have a bank account? Tell me about that. That is important, but I want objective data. Can they utilize this map? So self-report is tricky in these cases.

Q. Why is self-report tricky?

A. Some people will -- it's a response style. So some people will -- again, cloak of competency, say they

can do things they cannot do. Some will lack insight into what their strengths and weaknesses are. Some people may want to be found ID and exaggerate their deficits.

I think it's more of a lack of insight in part, and whether they actually know -- and you have to ask them if they know what you're talking about, you know. Do you know what that is? I guess we would call, is it reliable self-report?

And the AAIDD in the DSM -- or the AAIDD in particular will -- they do not recommend self-report assessments of adaptive functioning and instruments for self-report with ID or suspected ID folks.

Q. And is that because self-report is not necessarily accurate?

A. Yes. I mean, for whatever -- yes, for the reasons I mentioned, yes. So you want -- I try to -- I try to -- when I do these, I'll interview people just to get the information from them qualitatively and then try to look to see if they even know what Johnny could do. Some people you can just tell they just don't know. They're not going to be able to answer these questions.

So you want to look at, Who was he living with before his arrest, let's say, in a case like this, right? Even a girlfriend, mom, or whoever. And then you ask enough questions to where you believe that they can answer

this type of form.

Then you go over the form because the form is basically 0, 1, 2, 3, with specific criteria as to each score. And they often will just get in the habit of -- it's easier, it's human nature to say yes, no. Can you use a microwave? Yes. Well, no. It's 0, 1, 2, 3, you know? With assistance? You know, so it's detailed.

So, you know, ideally, you have quality informants, plural, you have more than one, but I had only one. I've had cases where we have none.

Q. But it sounds like you're saying it's important to triangulate between many sources and as many sources as you can, right? Records, collateral informants, people who knew the defendant and the diagnosis, and then the assessments you do yourself of the defendant?

A. Correct, and that really gives us what we call "convergent validity." So is the data we're getting, is it convergent? Does it make sense? Is it consistent? And it won't always be, but we try to get as much information as we can. I mean, we're never going to be able to interview everybody.

Q. So we were talking about gathering that information for the developmental period, and I think you've explained why the developmental period changed from 18 to 22?

A. Correct. And if I may, sometimes we have to do them retrospectively or -- and currently. So, you know, mom may be able to fill them out when he was age 10 or when he was age 20.

Q. So what are the causes of ID?

A. Well, you know, there are many. I mean, we usually don't know. So if Johnny has ID, 90 percent of the time we don't know why. 85 percent of the time. But it can be certainly prenatal, perinatal at birth, birth complications, you know, anoxic brain injuries, nuchal cord issues, premature births, exposure to neurotoxins, lead.

I've had domestic violence assaults on mom during pregnancy, which is a big part of what we think would be ID. You know, FAS, Fetal Alcohol Syndrome. We've had head injuries during childhood that was, I think, part of the ID finding.

Q. Let's switch gears and move to the American Psychiatric Association and the DSM. What is the DSM?

A. Diagnostic and Statistical Manual of Mental Disorders.

Q. When was the most recent volume published?

A. The fifth edition text revision was in 2022.

Q. And how does the DSM-5-TR define intellectual disability?

A. Initially, they refer to it as intellectual developmental disorder and it's characterized by deficits in mental abilities, reasoning, problem solving, planning, abstract thinking, judgment, again, academics, learning, and learning from experience. Very similar to the AAIDD.

They require impairments in adaptive functioning and -- we didn't really talk about this, but there's, like, a threshold of, Can this person live independently? Again, that gets to more of the needs and supports. Social responsibility. Then communication, relationships, work, academic functioning, and then, you know, independence in community or home settings.

Q. The diagnostic criteria?

A. So there's going to be deficits in intellectual functions. They, again, define them like we just did. Reasoning, problem solving, planning, abstract thinking, judgment, academics, learning, intellectual assessments, standardized assessment.

And then, again, the deficits in adaptive functioning. And deficits to the point where, you know, they struggle living independently without some type of support. And then having deficits in different domains, do you remember, like, again, the social community practical domains, and then it's got a developmental prong as well where, you know, the onset needs to have occurred

developmentally before, I would say again, age 22.

Q. So basically --

A. So the social, practical, and conceptual domains they cite, just like the AAIDD.

Q. And are there any differences between -- in substance, between what the DSM-5-TR is saying and what that AAIDD is saying?

A. Offhand on surface, no. I would say not really.

Q. Okay. And for the IQ, it's approximately two standard deviations below the mean?

A. Yes. Are you looking at the criteria?

Q. Yes. I think we've pretty much covered conceptual, social, and practical domains. Are there any differences between what's in the DSM-5-TR in terms of deficits and those domains and the AAIDD?

A. If we line them up, I'm sure the wording is a little bit different. I think the concepts of the adaptive domains are the same.

Q. How does DSM-5-TR assess the differences in the severity of the level of disability?

A. So they will look at, you know, mild, moderate, severe, and profound, like I discussed before, and they're related to, in much part, the adaptive functioning. They -- the APA and the AAIDD for years had focused much on the IQ score with the severity of levels and they --

they've gone away from that, more looking at the adaptive functioning levels.

Q. So how does DSM-5-TR now assess the severity --

A. So --

Q. -- of ID?

A. Yes. I mean, based on the three domains of adaptive functioning, you know, conceptual, social, practical, as well as their ability -- an individual's ability to live independently.

So when we -- I'm looking at, what, 55; is that where you're at? Yeah.

So they mention, like, a severe would result in a child having little understanding of written language or concepts involving numbers, quantity, and money, speech and communication being focused on here and now with everyday events. That would be social. The first one would be conceptual.

And then the practical severe, not being able to make a responsible decision regarding the well-being of self and others, necessitating supervision at all times.

So, you know, that's a lot of -- that's complicated assessment. In the DSM, there is like a chart where it will say, mild, moderate, severe, profound, and then give examples like this.

So the examiner, technically, has to look

through their records and interview folks and kind of see where they fit based on the severity level.

Q. Could you give us some specific examples of behavior, you know, mild, moderate, severe?

A. Yes. I'm going to -- maybe it will make it easier if I can -- I don't want to misquote the DSM, but -- so if I said mild -- I don't know if you have the DSM with you?

Q. I do.

A. I believe it's on your page -- it may be -- I don't know if it's 39 or 40. It's a chart. Table 1. Severity levels for intellectual developmental disorder. So what they have is a chart and some columns where it will say severity level. It will say mild. Then it will say a conceptual column, social column, practical column.

So mild -- there's a lot of information here, but I -- so I don't want to read it, just for brevity's sake, but I can -- what I'll do is, like, for example, mild, conceptual in adults, abstract thinking, executive functioning, priority setting, strategizing, short-term memory, functional use of academic skills like reading, money management, concrete approach to problems, solutions compared with age peers.

Under the social, under mild severity for adults, there's going to be some deficits, let's say, with

immaturity in their social interactions. Deficits in perceiving social cues. Concrete knowledge, information with limited abstract reasoning. You'll have some difficulties with impulsivity or emotional regulation, understanding some risks in social situations, gullibility.

And then practical domain would be -- like, under mild could be competitive employment is often seen in jobs that do not empathize conceptual skills. May need some support with healthcare decisions, legal decisions, and they may need support to learn -- vocational support for jobs. And they would need support often to appropriately raise a family.

Q. Dr. Fabian, do you have Table 1 in the DSM-5 on page 39 in front of you?

A. Yes.

Q. So in the practical domain for mild intellectual developmental disorder or intellectual disability, the DSM-5 says: That the individual may function age appropriately in personal care, right?

A. Yes.

Q. However, individuals generally need support to make healthcare decisions and legal decisions?

A. Correct.

Q. And that's consistent with your understanding of

mild ID?

A. Yes.

Q. Okay. Now, in the conceptual domain, it also says: For preschool children, there may be no obvious conceptual differences?

A. That is correct. Yeah, it just may not be observable at that time.

Q. But as children age and as the tasks become more difficult, that's when mild ID becomes more apparent; is that fair?

A. Very fair. That's usually often that I see in the middle part of elementary school, fourth to sixth grade, that's really where abstract thought gets more intense with school.

Q. And they can't keep up?

A. They often start struggling. Then it becomes more observant in some cases, often in the mild folks.

Q. And in the social domain with mild ID, social judgment is immature for the age?

A. Right.

Q. And a person is at risk of being manipulated and gullible?

A. Correct.

Q. And that's just mild ID?

A. Right. But you don't need impairments with all

of the domains you just said. You just have deficits in one.

THE COURT: Ms. Russell, now is probably a good time to take a break. It's almost 2:30.

MS. RUSSELL: Sure.

THE COURT: So we've been going for about two hours, I'm sure the doctor would like a break. So I will see you all back here in 10 minutes.

(Break taken.)

THE COURT: Whenever you're ready.

BY MS. RUSSELL:

Q. Dr. Fabian, is intellectual disability ever confused with other diagnoses?

A. Yes. Learning disabilities, learning disorders, and they can be looked at different ways, but typically, learning disability, learning disorder is when there's a significant disparity between IQ and ability and academic achievement. With ID, typically both are deficient.

Mental illness. At times, individuals with chronic schizophrenia that is severe, they can be confused with based on other factors, especially what we call negative symptoms of schizophrenia, which are described by, you know, poor communication skills, thought blocking, thought delays, difficulties in some of their life functioning.

Other, you know, on some cases, a person may have low intelligence, but higher adaptive functioning skills.

And then Autism Spectrum Disorder where some of their communication -- they will have communication or a language delay, but they may also have, you know, again, emotional, social deficits that one may, you know, have difficulties just on their face differentiating, especially if they're not, like, an expert of evaluating those folks.

Q. Let's talk about best practices in assessing ID.

A. Okay. So, yeah. Briefly, we're going to use accepted intelligence tests, such as, you know, the WAIS, Wechsler Adult Intelligence Scale, now in its fifth edition. We're going to also assess academic achievement skills, and other neuropsychological functioning tests that are going to get at some of these executive functioning skills, motor skills, sensory motor, perceptual reasoning skills.

And then also ideally using adaptive functioning skill -- or scale with an informant that is informed, so that they know this individual pretty well in order to be able to be deemed a collateral informant, a reliable one for this type of case.

Q. Anything else about best practices in

interpreting scores?

A. Well, you want to -- obviously, when you're interpreting this data, you're also looking at records and other collateral information that you may have. I do like to assess one on one some adaptive functioning skill sets with, you know, tests that are appropriately normed.

So there are some practical adaptive functioning neuropsychological type tests out there that I may use, or I may also use certain parts of other tests that look into their ability to understand, let's say, what a will is, and then practical reasoning about healthcare, okay. What to do in different scenarios, for example, which gets more into the practical domain of functioning. And you're considering, you know, these test results based on practice effects, personal or environmental community factors.

Q. Let's talk about best practices in diagnosis.

A. Well, you know, there's going to be a psychologist, a neuropsychologist, typically. A psychiatrist can, but they're going to need some of this testing data as well.

Then we're looking at, again, standardized tests, collateral interviews, and review of appropriate collateral records.

And then again, there may be linguistic cultural

issues, especially folks that are born in other countries, you know, English as a second language issues.

Q. So let's talk about a standardized IQ test.

A. Okay. There are several. I have four of them, I think, I own. And they are normed throughout the country with different populations, children, adolescents, and adults, depending on the IQ test. When we're looking -- I made mention before, the average here in a bell curve of the population is 100, and each standard deviation is 15 points above or below that mean.

The really, really intelligent folks, let's say, at the second percentile are going to be around a 130 IQ, and the folks at the other spectrum ID are going to be a 70.

Q. So that two standard deviations we were talking about, what percentage of the population is that?

A. The second percentile.

Q. And that's just for mild ID?

A. Yes.

Q. Someone with a 55 IQ, would be where on the bell curve?

A. They're still in the mild. Mild, based on former DSM data is, like, 50 to 55 is 70, 75.

Moderate is more of that 50 level and below to 40. That's kind of traditionally how we look at that by

IQ.

Q. And in terms of the percentage of the population in that 55 range?

A. About 1 percent, I would say.

Q. That's low?

A. Very low.

Q. These are the IQ tests, the four IQ tests you use?

A. Yes. These are four IQ tests I have. Actually, I have the Woodcock Johnson IV. I don't have the V yet, but those are four that I would say are most widely used with the WAIS-5 being the most prominent on the list.

Q. And the WAIS-5 recently came out, right?

A. Yes.

Q. When did it recently come out?

A. In the fall of '24.

Q. And before that, people were using?

A. The WAIS-4.

Q. WAIS-4.

How long had the WAIS-4 been around?

A. Since 2008, I believe.

Q. Well, let's talk about the WAIS-4.

A. Sure. So we typically use about 10 subtests. The WAIS-5 has more, and I like that, but you didn't ask me about that.

Q. Do you feel like the WAIS-5 is a better test?

A. Yeah. I mean, it should be more psychometrically sound. I haven't compared it exactly, but there is more executive functioning, and it's more neuropsychological friendly and comprehensive than the WAIS-4. There's probably 18 subtests. You only need 7 instead of 10 for a full scale, and I'm still tinkering with it, but I like it.

But traditional WAIS-4 would be four domains of intelligence. The first two are really the traditional domains. Back in the day, it was really focused more on that. It was really verbal comprehension. We call that, like, crystallized intelligence, and that is, in most part, learned. Vocabulary. Fund of knowledge. Jeopardy-type information. Verbal Comprehension Index. Then Perceptual Reasoning is more of that fluid intelligence. Basically, kind of more innate intelligence.

But the two last ones, working memory and processing speed, are really attentional, but they are tests. So, again, working memory. That line between attention, memory, executive functioning, manipulating information in mind, and processing speed, of really how fast and efficient you can solve problems. It also has to do with psychomotor coordination. The four of them have

multiple subtests within each of them. And that gets into, actually, Slide 67. These are --

Q. How many subtests are there on the WAIS-4?

A. Well, including supplemental subtests, 15. And really, we look at the 7, 6, 8, 9, 10. When I administer these, I usually do the core subtest and the comprehension of -- verbal comprehension.

Q. And those subtests are basically correlated to certain skills? For example, Processing Speed Index, Working Memory Index, Comprehension Index, and Perceptual Reasoning Index, right?

A. Yes.

Q. And some of them correlate to more than one?

A. Yes.

Q. Okay.

A. Uh-huh.

Q. Okay. And that's all because the WAIS people who developed the test at the American Psychological Association?

A. Yeah. I mean, they're psychologists and researchers as well, yeah. And the WISC-V is out as well. That's the Wechsler Intelligence Scale for Children.

Q. And what does that use?

A. That would be typically up to age 16, yeah. And there is the, I think, WISC-V. That's for preschool

before the WISC.

Q. So when assessing adaptive functioning, you've talked about having a broad base of records and information from different sources, much of it retrospective. Where can we look to find that kind of information?

A. Well, you could find work records, you know, mental health records, school records. There could be different, I guess, clubs, activities, different certifications, vocational certifications. Those types of records. CPS records or DCF records, you know. Then we have on there, like, banking records, driver's license, legal records, probation records, social services records, birth records.

Q. And all of this information might inform whether or not there are deficits in the social, conceptual, or practical domains, right?

A. Correct.

Q. Tell us more about assessing adaptive functioning.

A. Well, gathering those records. And then I would say ideally, if you find a reliable collateral informant or informants, you can either interview them separately or together. I've done both. You know, with mom, dad, aunts, uncles, siblings. I would say probably

individually is better to do, and then maybe collectively.

Then also, if you find those individuals, then to have them, you know, answer, fill out adaptive functioning assessment instruments. And, again, there's going to be several of those that we can brush on that are going to be appropriate, like the IQ test I just reviewed.

You know, the goal -- the last bullet is kind of like, Measure how well a person functions on an independent level and provide direction for optimal support. So this type of context is a bit different, obviously, but, you know, that's what it really is designed for traditionally is needs and supports and figuring out strengths, weaknesses, limitations. Then what could we do with this person based on those scores and abilities or deficits.

Q. So tell me about the Practice Guidelines Regarding the Assessment of Adaptive Behavior?

A. Okay. So we're looking at adaptive functioning instruments that are normed on the general population, but then with and without disabilities. And you're looking at a -- typically, these instruments will have a global score, like a GAD, Global Adaptive -- or Global Adaptive Composite, like a GAC, which is kind of like a full-scale IQ that, instead of four domains of IQ, we just went over it, it will have, like, the conceptual, social, practical

domains, for example, that coincide with the -- you know the AAIDD and the DSM, you know, domains.

And then we want to appreciate that this adaptive behavior is typical and not at their best. So they're kind of average skills in those areas, and we're hoping that whatever collateral informant we use, they know that person well enough to provide that information.

And then also did we observe -- you know, did they observe that person on a daily, weekly basis, and across multiple community contexts. Now, that is sometimes difficult, but we do the best we can with these types of cases in trying to find folks that knew the person.

Q. Okay. And how important is it that that person who is a collateral interviewer has directly observed the behavior that they're speaking about?

A. Yeah, I mean, that's -- that's really a necessity. So some scales allow you to say when they're -- let's say that the mother has never seen their child do a particular question, you know. What -- if given the opportunity, how do you think they would do. So they can answer it that way as well, if they've not observed it, but we want that person to be able to answer a lot of those questions on the test.

Q. What is the ABAS?

A. So the Adaptive Behavior Assessment System, it's in its third edition. That is one of those types of tests. So it does go from childhood into adulthood. It does allow for us to score that person's score based on, well, if given the opportunity, you have not seen them do particular tasks, how would they do it if they were exposed, let's say?

That, again, is rated by a caregiver, someone that -- or a family member, someone that knows them in different, let's say, context.

Q. And does it identify individual strengths and weaknesses?

A. Yes. So strengths, limitations, and, again, it will -- the assessment is, again, designed to then line up appropriate resources and supports for those needs or limitations.

Q. And, in general, those assessments are done thinking about the individual in the community-based setting?

A. Yes. That's where -- that's exactly where they would be in the community. So it's not based in jail, prison, or, you know.

Q. So this is an example of the way the scoring is done on --

A. That is --

Q. -- ABAS-3?

A. That is exactly correct.

Q. And has basically scores for each domain; conceptual, social, and practical?

A. Yes. And you can see each domain, like communication, functional academics, self-direction, are under the conceptual domain. So they have a few subtests per domain.

Q. Then there's that General Adaptive Composite, and that's the scale score?

A. Yeah. That's like your full-scale adaptive score, yes.

Q. And that would have to be two standard deviations below the norm?

A. Yes. And that would -- that would, again, include your standard of measurement, yes.

Q. What about the Vineland Adaptive Behavior Scale?

A. Yes. Very similar measuring adaptive functioning presenting, like, an overall adaptive functioning score. This one is not -- not delivered to the subject being evaluated, but it's, I think, to, you know, family, collateral caregivers.

That one also has -- looking at communication, daily living skills, that's more practical. Socialization, social skills, problem solving, motor

functioning, and it can also be used to assess behavioral disorders that may impact some of the physical disabilities.

Q. So the ABAS and the Vineland are both created specifically for the assessment of adaptive functioning in the intellectual disability context; is that correct?

A. Correct.

Q. And what makes them good measures of that in this context?

A. Well, the construct, validity, the psychometrics is designed to assess the definitions of what the AAIDD will refer to, as far as these adaptive functioning skills or deficits relevant to the diagnosis. Plus, they're normed in different populations, including folks with ID.

Q. Are you familiar with the WHODAS 2.0?

A. Yes. That is World Health Organization Disability or -- DAS, Developmental Adaptive Schedule or Second Edition. Well, what it is is it covers adaptive functioning in these types of different domains, and it is, I think, based in self-report of the subject.

Q. It's an open source that's available on the internet?

A. Yes.

Q. Is it scientifically valid for assessing adaptive functioning in the context of intellectual

disability, or is it more of a general disability type --

A. Well --

Q. -- assessment?

A. -- I would say it's more of the latter. I look at it as more of a guide, as kind of maybe -- if you're to use it, it would be more of like a structured interview. When I evaluate, it can be an ID case. It doesn't have to be an Atkins case. It can be some other type of forensic matter.

I will ask this individual I'm evaluating a lot of these questions, okay, and I'm relying on their self-report. Have you ever had a bank account? How did you get money? Do you have a -- do you have a, you know, caregiver? Have you ever lived independently? Do you drive a car? Do you have medical insurance? How many times did you take the driver's license? GED? What grade did you finish?

All of that type of information we would do, but then I -- and the WHODAS, I think, is fine to do as a structured interview, but the AAIDD does not support that as being adaptive functioning assessment in an intellectual disability evaluation.

Q. Why is that?

A. Well, it's self-report. So they adhere to, again, a collateral informant providing information.

Q. And would the fact that it is only 30 days retrospective also be an issue since adaptive functioning should be assessed during the developmental period?

A. Well, yes. I will say that would be current, but, like, let's say if they're in jail or a psych hospital, you know, we're also going to want to know how you are doing currently in the community.

So I think it acts as a structured kind of clinical interview of -- you know, you can ask them how they're doing currently, even if they're in a facility, but that is not going to be really relevant to an ID assessment in a case like this.

Q. Okay. We're going to talk about that a little bit more, but let's make sure we've covered self-report.

Why is self-report not the best method?

A. Well, again, it can be -- you know, a person can be susceptible to biased reporting either way, okay. They can exaggerate, minimize their skills, or have lack of insight into that, and that would be the most concern that I have in this type of case.

So I like to do, like, the comprehension testing on the IQ or in a neuropsychological assessment battery because that's function here and now. Do you know the answer? What do you do in this circumstance, and that requires knowledge.

So, you know, a lot of people can say a lot of things and they exaggerate or minimize their skills and there's really no way for me to assess the validity other than they may say they drive a car, and I know they never have because I talked to 12 family members. So there's not a way to validity check it within the instrument itself.

Q. Are inaccuracies in self-report always a result of intentional misrepresentation?

A. No.

Q. Why is that?

A. They may lack insight, and they may confabulate. They may not understand the question they're being asked. Like, an interview, no different. Do you know what a plea bargain is? Do you know what X, Y, or Z is in an adaptive functioning setting? They may not know what you're talking about.

Q. All right. Let's switch gears and talk about adaptive functioning in structured environments like institutions, prisons, hospitals.

A. Okay.

Q. Why is assessing adaptive functioning in the institutional setting disfavored?

A. Well, you know, obviously, a lot of things are being done for that person. So, you know, they don't have

to get health insurance, buy a car, get car insurance, go to the grocery store, find a way to get food, things of that nature. So it's more of a structured setting, and a lot of things are taken care of for them.

There are really no normed adaptive functioning tests with folks that are in correctional facilities, and it's not always advisable to interview correctional officers that may or may not know this defendant. It's just like a structured kind of artificial setting, and it is not a community where AAIDD is really based in its development of assessing someone who is intellectually disabled. It's a developmental disorder, and the kid wasn't born in a prison.

Q. Okay. Have you ever heard institutions like prisons and hospitals been referred to as the "ultimate group home"?

A. Yes, I have.

Q. What does that refer to?

A. Well, two things: Some of the folks, you know, we evaluate and represent have always been either in a group home, a juvenile detention facility, and now in prison, but a group home is, you know, the things are there. They're provided, in part, for you. So you don't have to show and exhibit as much to receive.

Like, you don't want to have to go and sometimes

buy your food or find a way for transportation, money to do this, that, or the other. Live independently. You're not living independently. That's the AAIDD's goal, is to what supports do you need to live independently? In a prison setting, the person is not.

Q. There are many cognitive tests that you can use to assess adaptive behavior, right?

A. Yes.

Q. And those are listed inside 79?

A. Yeah, and just real quick on that. When you're doing this type of assessment, the clinician/examiner must do an IQ test, academic achievement test, and an adaptive functioning test, assuming you have a reliable informant. The last two are for -- the first, let's say, the AAB, KTEA through the -- those are all academic achievement tests, reading, writing, spelling, math that really need to be done with this type of assessment, and that's in the area of conceptual adaptive functioning.

The last few should also be done as well because they do hit on language.

Q. Do you think it's important as a neuropsychologist to know what the reading level is of someone before you give them a test?

A. Well, that's how you find out. So, yeah, the first few, you find out their reading level.

Q. Before you give further testing?

A. I think it's a good idea, especially when we have more complicated cases that may require. Like, forensic assessment instruments, some require reading, and also, some require oral comprehension. I'm asking you, let's say: Are you malingering psychiatric symptoms?

Let's say the guy may have schizophrenia. So I may ask them -- do a test orally that assesses psychiatric symptoms, and I want to know if they can understand the questions. Or maybe it's a true-false that looks at credibility of psychiatric symptoms.

You typically want to know their reading level before I give them a psychological test. The Personality Assessment Inventory, the PAI, that's a fourth grade level of reading. I'm not going to give it to the person if they don't have a fourth grade level of reading.

THE COURT: How are you going to determine their reading level if you already think they have a credibility problem as it relates to malingering?

THE WITNESS: Malingering of mental illness?

THE COURT: Yeah. You just mentioned a lot about self-reporting, and how it's not necessarily the best way to go, and people can exaggerate symptoms or try and cover up symptoms.

But in this case, we're talking about not

someone who is applying for benefits or trying to get an IEP done a certain way for particular educational purposes, but someone who is facing criminal charges.

So how would you even know their reading level is accurate?

THE WITNESS: Well, that's a good question. A couple of things -- well, we want to know -- well, do we have reading school records just to see by history their reading skills. So that's one way. It's their history -- historically.

I would give them, let's say, the test and see if they can read it in front of me, which I would want to do now, and you could then say, Well, what if they're faking? Do you know if they are or not?

Two things with this: One, in psychology, we can assess someone whether they're exaggerating, feigning, malingering mental illness. Often schizophrenia. In neuropsychology, we're looking if they're exaggerating, feigning, malingering cognitive deficits, okay.

So I do both of those depending on the case, and those -- the latter is more related to, like, effort testing.

THE COURT: That's the point I'm trying to make is that --

THE WITNESS: Yes. So I want to assess that --

THE COURT: In the last round of hearings, we had really as to Mr. Mosley, there was a lot of conversation related to effort. So how am I supposed to make that determination, whether or not he's putting forth his full efforts in any testing that anybody is giving? How do I know?

THE WITNESS: Sure. So I, first of all, appreciate your conundrum. This is deep weeds in the field.

THE COURT: It sure is.

THE WITNESS: It sure is, okay. And you know what? I mean, there are -- in 2025, we do the best we can. Recently, we had an Atkins hearing in Florida having these issues. And I'm putting the cart before the horse, but the judge asked so --

THE COURT: I'm sorry. I sort of skipped ahead.

THE WITNESS: No, you're fine. And one of the problems here is that, in some cases -- and I end up getting referred smorgasbords and buffets, as I call them, where they had every problem potentially in the world, but two big ones are schizophrenia and intellectual disability, okay?

And the person -- those are the two most profound disorders in that DSM you have over there,

okay. You want to look at effort testing, but there's a caveat because there's probably only a few that are pretty well normed with folks with ID. They're often normed with folks with traumatic brain injury, dementia, but not cleanly ID.

And so -- but we have a number of different types of effort tests that we use, and you may have heard about them. So there's a few that I use that are, I think, better than other ones with this population.

You're also kind of looking at convergent validity as to see, well, how many has he passed or how many has he failed and how much has he failed by? The other thing you need to know is that these two populations -- let's say, ID. There are often more false positive results saying the instrument says -- kind of falsely stating they're malingering when they're not.

And it's even more of a chance of that when the person has a co-occurring schizophrenia condition. They're ID and schizophrenia because they're more likely to be disengaged, and that is not malingering.

So when we look at these assessments --

THE COURT: Well, explain the difference between the two.

THE WITNESS: Sure. I look at -- you know, there's different -- there's different semantics here, but, like, you could have -- you could pass a test cleanly, and I'll say it's valid. You could have more confidence than the testing I do after that are valid.

So when I go into this jail Saturday in Dallas with this woman, I'm going to start with an effort test, and I'm not going to tell her this, and I want to see where she's at. And -- so you could have if you pass -- typically, we give more than one effort test. I know this -- and you may -- yeah, I think you've heard of this.

THE COURT: I may have heard of a few of the tests.

THE WITNESS: Sure, you have. But you also have three standing effort tests, and the test is designed, and this is what it is. It's an effort test, okay?

Then there's embedded. You may have heard that. That means, in an IQ test, there may be one or two scales in that IQ that we can say are embedded to look at effort, and I typically do both.

So -- and I don't know if I should, I guess, reference. So, I mean, so reliable digits in the

digits span of the IQ is an embedded effort test, but then I have -- you may have heard the test of memory malingering, the TOMM, which is, by itself, an effort test. These are very simple tests that folks with moderate to severe TBI, dementia pass.

Now, if you pass most all, we could have more confidence that you're trying, put forth pretty good effort, and that whatever we do beyond that, like an IQ test, is valid. It's kind of representative of your true intellectual cognitive, ability whatever that test measures, okay?

So we have pass valid, valid, responding. The other thing I said it's kind of variable suboptimal effort. Somebody may say it's poor. That's kind of the disengagement variable. So when we look at these tests, often it's kind of, like, they have two choices.

And below chance, you know that they're basically saying, you know -- they're basically feigning and manipulating.

The pass is often like at a 95 percent clip because they're easy tests. When you're somewhere in that above the 50 chance, you're kind of looking at the variable effort. The variable effort can be different based on different things. They're in a

jail/prison, they're looking at the death penalty.

They have ADHD, PTSD, the trauma of killing someone, okay. Like, psychiatric pain, medical issues, a combination, right? The more tests you fail even above chance, the more likely we may say there's manipulation.

However, when you get someone with suspected intellectual disability and schizophrenia, you're going to have failures. You should expect them. It shouldn't be below chance, but you're going to fail the effort tests. There's going to be disengagement.

And where that comes in in the research is the negative symptoms of schizophrenia. The positive ones are the ones we hear about, hearing voices, delusions, seeing things, hearing things. That's not as significant. It can be if they're actively psychotic at that moment.

The negative symptoms: Avolition, lack of motivation, initiative, disengagement, spontaneity in speech, blunted affect, flatness, not caring, maybe lacking insight as well. Not caring, not in pejorative way, but disengaged.

So when you have that, and that these tests are not normed on folks with ID often, the double whammy is schizophrenia and intellectual disability. You're

going to probably find more -- one or more effort tests that are failed.

You want to make sure you look at -- you know, they're 85 percent, 75 percent. That may not be that they're, like, manipulating. So it's not just all catchall, you're valid or you're malingering. If you fail an effort test, again, you're going to expect that in -- when someone is that impaired psychiatrically and cognitively.

But then the issue is, okay. Well, if they failed and you have other testing, what's that other testing worth, right? So if you fail and the person has a particular IQ score, is it really that low?

Then you kind of have to make a judgment as a clinician -- and it depends on the case. I don't have all the numbers nor am I going to be answering about this case.

THE COURT: I understand.

THE WITNESS: Okay. So that's kind of how I look at it. There may not be a perfect true score because of human nature, you know. Like, in a case with schizophrenia and intellectual disability, that person -- these are the most profound conditions that are known to man.

Is there anything else?

THE COURT: I think that answers my question. Sorry to interrupt.

THE WITNESS: You're fine.

BY MS. RUSSELL:

Q. So we were just going to head into our discussion about malingering and symptom validity and test validity. So we're trying to move quickly through it since some of it was covered.

A. Okay.

Q. Dr. Fabian, how important is it that effort testing is chosen for the particular situation and is appropriate for the situation? In other words, how important is it that effort testing is normed on people who have cognitive impairment?

A. Well, I mean, it's really important because you want to ideally assess -- the assessments and tests you use, you want to have been tested and normed on the population you're assessing, okay.

So, you know, you want to -- really, you can't use those tests, you know, unless it's really normed and tested on the person you're examining, and whether -- it's hard to have exactly -- some people have a lot of deficits, right, but they need to be -- or conditions, but they should be normed. You need to use an assessment test that is really normed to the population you're assessing.

Q. So how do we figure out if someone is malingering intellectual disability? I'm on Slide 82.

A. I'm processing your question. Well, if Johnny had special education when he was aged 8, was he malingering in the second grade? Probably not. That's one way.

Q. There is --

A. The records --

Q. Sorry.

A. Go ahead.

Q. There would be no secondary gain in elementary school?

A. Well, I mean, consciously, typically not. I think that sometimes you'll see notes that will say, this may not be a valid or reliable, you know, assessment of their intellectual function when they're age eight or twelve, but that may be because of the domestic violence going on in the home that the teacher knows about. There could be other variables.

But, typically, I mean, kids are relatively motivated. They may be ADHD running around, and usually, there's clinical signs and the mental status and then the IQ results that will be discussed by this psycho-educational school psychiatrist, you know? So you want to look at those records. We start with that, okay.

Then you want to look -- you know, is there a correlation between malingering and, let's say, criminality? Yeah. Antisocial personality disorder? Yeah. Length of criminal offending? Yes. Chronicity, yes. But you also want to look at the history of, you know, their deficits or disability, their mental health records, et cetera.

Also, just some other factors as to collateral information as to, Did they understand? Did they get fired from work because they didn't understand what they were doing? Couldn't catch on, et cetera.

So there are other markers that are separate from just scores. So, again, that mental synthesizing information from multiple sources. The self-report, again, is we get into, you know, that can be a problem both for and against. They may exaggerate or minimize deficits.

You know, some of these cases I have they -- like the one, this gentleman did not want to be found ID because he got beat up, and he was always saying yes to everything, and he did not know really the questions I was asking him. He would just say, yeah, I understand when they don't. That's the cloak of confidence.

Again, most of those instruments have not been cleanly normed on the folks with ID. Some of them have.

A couple of my users are more normed on, like, fetal alcohol children that are found to be ID. And I may say, Well, they may have been low -- lower functioning than an adult with ID, you know?

But, you know, we're mixing a little bit of apples and oranges. We do the best we can. We look at trends, and we want to look at kind of the number of, you know, validity markers that are given and their results.

THE COURT: Can I ask a question? I'm sorry.

Environmental factors are certainly a consideration because that was something we just -- I think you just -- I'm using a different word than you, I think, but this is something that's come up before, and I think you just touched on it, that, for example, a child could be on an IEP in school because mom and dad fight, and they don't sleep at night. Therefore, they don't perform well at school or mom and dad aren't checking their homework or mom goes out all night. There's no dad in the home.

I mean, I can think of the various scenarios when I was in family court of reasons why during a divorce, for example, children might not do so well in school at a very early age and it's not -- it doesn't appear as if it's related to a mental illness or an intellectual disability, but they --

environmentally, there's something going on outside of school do not perform well in school.

Does that make sense? Did I explain that?

THE WITNESS: Yes. Absolutely.

THE COURT: Okay. You touched on it a little bit, but I think you would agree with me that environmental factors, when I'm looking through historical data, could be relevant.

THE WITNESS: Yes.

Can I respond?

THE COURT: Yes, please.

THE WITNESS: Okay. When someone is really low functioning, you can't put all the eggs in that basket.

THE COURT: Correct.

THE WITNESS: Often when they are low functioning, they're going to be tested, hopefully ideally, depending on the school system, at multiple junctures. They may often be in the same home, but, you know, there may be days when they're tested, when it's a good day or a healthier day.

THE COURT: Right.

THE WITNESS: The other thing is, often there will be a note in that, you know, where the -- they don't test effort in elementary school, okay.

THE COURT: Right.

THE WITNESS: Now, they often don't. I worked at juvenile court in Cleveland, Ohio, for 10 years, and we weren't really testing effort either where it really should have been, okay? Now they are doing that more with juvies.

I always -- whenever I do juvenile exams, I do effort testing, and now there's more test assessing them as well. So with that said, when there's multiple testing points, usually, there's some valid scores there somewhere, okay?

Now, ADHD can also get in the way. Are we looking at learning problems or emotional behavioral, or is it PTSD trauma and ADHD? Kids are complicated, so are their lives and environments, as you say. So with that said, usually -- I -- I rarely see a kid that's been tested multiple times where every time it's said, Oh, this is a valid marker.

THE COURT: Well, yes. Just to Ms. Russell's point that, at a certain age, there's really no secondary gain to not put forth the effort, say, in elementary or middle school. There's something else going on. There's either a true intellectual disability, a learning disability, environmental factors. It could be a whole host of different

things that could make, for example, a child needs an IEP.

THE WITNESS: Correct. And in that, when they have the ARD Committee, you're doing interviews with different teachers that are observing the classroom, ideally, and then also doing interviews. They're doing their own BASC, behavioral assessment of systems checklist, or their A-BASC where in those notes or in those tasks it will say, Johnny doesn't understand directions and that's just not an IQ score based on -- you know, these are observations that are just not about what's going on at home.

THE COURT: Right.

THE WITNESS: The true low functioning comes out.

THE COURT: Sorry to interrupt again.

MS. RUSSELL: No worries, Your Honor.

BY MS. RUSSELL:

Q. The TOMM and the Rey 15 are effort tests normed for people who are cognitively impaired?

A. Yes, but really not ID. The TOMM -- the TOMM even has an article by Christopher Ray, R-A-Y, and he did some studies on this, where he suggests a lower cutoff score for those with ID because of the false positives of that test found with folks with ID.

So falsely saying, this test, the person failed, and you're falsely saying they're malingering or having poor effort when they're not, okay. A failed effort test does not equate with malingering, okay? It equates with suboptimal effort, disengagement. Maybe malingering. It just depends kind of on how bad they failed, how many of them they failed, et cetera.

Q. Are you aware of whether the VIP and the M-FAST are normed for people with cognitive problems?

A. They're not. I mean, so the VIP, Validity Indicator Profile, is not recommended to be used with folks with ID. That gets into some cognitive effort, but the M-FAST, Miller Forensic Assessment of Symptoms Test, is me reading questions saying: Do you hear voices only on Tuesdays when you're hungry? I'm making that up, but it's kind of the gist. That person needs to understand what you're saying, and that is tricky when you're evaluating someone with ID.

It's oral comprehension, auditory comprehension. They're not reading, so you want to know -- well, ideally, you want to test their auditory oral comprehension to really see where they're at.

They're also -- so, really, it's about psychiatric symptoms and really about schizophrenia symptoms, and 23 of the 25 items are about schizophrenia,

I would say. So this was not a cognitive effort. It's not about cognition. It's about psychiatric symptoms.

It is really at norm with folks with ID, so you've got to be careful when you give that because you're going to be more likely to have false positives with that because folks could be naysayers they can also malinger, but it's -- you have to be careful with that with folks that are low functioning.

Q. That dovetails perfectly with a discussion of the differences between performance validity and symptom validity.

Tell us what is Performance Validity Testing?

A. That's more of, like, the TOMM. So we're looking at performance, its function. So it's really looking at visual, learning, memory, and effort. The cognitive skills set is visual, learning, and memory, but it really is designed to assess effort.

And then the symptom validity can be like a Personality Assessment Inventory, the MMPI. Also, like the M-FAST where you're looking at psychiatric symptoms.

Q. So do symptom validity tests tell us anything about effort?

A. No. And I had cases where the individual is malingering on the M-FAST and not on the TOMM.

Q. And what does that tell you?

A. Well, they could be ID and not schizophrenic or exaggerating schizophrenia. Let's say they tested it in the ID range. I've had cases like that. It's complicated, but I can say, Hey, they passed the TOMM, and they have a 70 IQ. It looks pretty valid, but they're exaggerating psychotic symptoms or vice versa.

Q. I know you touched on this super briefly, but just to cover all our bases, could you tell us how performance validity tests are categorized?

A. Yes. Stand-alone or embedded. So embedded within the measure, the cognitive or neuropsychological or intelligence test kind of hidden in there. It's not really designed to do it, but there's been research on it subsequent to the manufacturing of the test, versus stand-alone, where it's really kind of designed to measure that effort.

Q. Dr. Fabian, are there embedded measures of effort on the WAIS?

A. Yes.

Q. What are they?

A. The one I use is reliable digits span, RDS. I believe there's a vocabulary one as well of a particular, I think, threshold of -- I think the raw score -- I forget the cutoff. I use reliable digits span forwards and backwards. I can share it with you. I don't know if you

want to know more about it.

Q. Okay. Is there anything else we need to know about performance and symptom testing in populations with intellectual disability?

A. No. I mean, not at this point.

Q. All right. How do medications affect testing?

A. Well, I mean, depending on the -- I know studies cited, the medication, how long the person has been on the meds, dosages, other comorbid symptoms, et cetera, it can have an effect.

Now, once stabilized, it can improve the person's functioning, but it also can lead to impairments. So I want to say, you know, for the Court, there are neuro-cognitive effects or sequelae to mental illness. So our field has changed from, you know, PTSD, you have flashbacks, you have nightmares of a traumatic event or events, or you're schizophrenic and you hear or see things or have delusions, to more being brain-based disorders where they -- we know now where schizophrenia is housed, and that area is where kind of memory is as well and some executive functioning.

So there's going to be some neuro-cognitive effects of the mental illness, but also from the medication being used. So the antipsychotic medication depending, again, on dosages, et cetera, can impact one's

cognitive performance, also their effort, their engagement, et cetera.

Q. What's "co-morbidity"?

A. Just when someone has, you know, more than one psychiatric disorder at the same time.

Q. Are people with ID more likely to have other syndromes?

A. Absolutely.

Q. Okay.

A. Yes.

Q. Okay. How so? Is it a high risk of co-occurring mental health conditions?

A. And medical and neurological. They're simplistically just less resilient than the typical person. So they're going to be more at risk for physical anomalies, conditions, and mental. So often when you have a neuro-developmental disorder, you're at high risk for another one.

Q. And, in fact, that would be three to four times higher than in the general population; is that what the DSM says?

A. Yes. So, typically, if you have ID, you're going to have a co-occurring ADHD and/or autism, and autism will place you at risk to develop schizophrenia.

Q. So what are the most common neuro-developmental

disorders that come with ID?

A. Usually, I will see LD and ADHD. So, like, a learning disorder and ADHD, comorbid. Probably in a 30 or more rate.

Q. And what about other neuro-cognitive disorders?

A. Well, yeah. I mean, with ID and ASD -- and again, that -- if I may. When you look at ID, they're so impaired in so many areas cognitive, emotional, behavioral, social you forget that they can be autistic, you know? Because they're just ID, you know? And I think that's becoming more relevant in our field. We should really be assessing both.

So the rates are pretty high that when someone is ID, they're going to have other, like, neuro-developmental conditions. Also psychiatric, like, conditions. Especially, like, anxiety, sometimes depression.

Q. Let's talk about ID and autism and the relationship between the two.

A. Sure. Right. Well, I have seen studies when it is, like, 30 percent, even 50 percent. So folks with ID are going to have language delays, which is necessary for autism, and they're going to have difficulties in some of the areas -- like, a number of the diagnostic criteria for ASD that we'll see just in a minute.

Q. So, Dr. Fabian, just because we're running a little bit short on time --

A. Sure.

Q. -- we do have all the ASD criteria.

A. Yeah.

Q. Could you just point out, as we scroll through them, what symptoms are similar or, in fact, identical between intellectual disability and ASD?

A. All right.

Q. Being Autism Spectrum Disorder.

A. So a difficulty with back-and-forth conversation, emotional reciprocity, sharing of information, emotions, empathy, kind of really appreciating how other people may feel or think, initiative, and appreciating, let's say, nonverbal communication, language deficits, problems appreciating, identifying nonverbal cues.

And then perhaps deficits in developing, keeping relationships. Problems, you know, with imagination. Interest in peer groups. Now, a lot of folks with ID do have those skills, so I think it's more of just appreciating other's emotions, understanding, you know, jokes, let's say.

Now, some of that is going to be mixed with cognitive versus emotional or social deficits, but when we

look, social domain is one of the domains of adaptive functioning deficits. So they do overlap.

Q. What about symptoms of autism as they might affect competency?

A. I've seen difficulties appreciating charges or really the consequences of their offending behaviors, leading to the severity of the charge and consequence. I've seen that in different cases. They may be able, on the face, understand that rape was a sex -- you know, committing a sex crime against someone, but the shared experience of a sexual encounter is often different between, let's say, a woman normal and a man that has autism. Does no mean no? Appreciating that, especially if they have had sex before, let's say, and appreciating that context, and then looking at life, rape, as a consequence. I've seen that before, for example.

Q. What about inappropriate facial gestures, inappropriate laughter, that kind of thing? How does that play in front of a jury?

A. Well, yeah. I mean, just as far as the -- they may -- well, if someone is, like, testifying, let's say, just some of the emotional cuing they may not really appreciate facial gestures, and especially if they have suspected ID and ASD together, and even schizophrenia.

Q. All right. Let's talk about schizophrenia.

A. As noted, you know, the positive symptoms we often see hallucinations, hearing things, seeing things. Delusions, having false beliefs. Then disorganized behavior, speech, incoherence, derailments, all of these types of, you know, psycho lingo that shows that they are nonsensical, disorganized in thoughts and speech, and hard to follow in their own world, really, with just a lack of contact with reality, which is the hallmark of schizophrenia.

And that can also lead, you know, to negative symptoms. That would, you know, the blunted lack of emotional expression; Avolition, again, leading to a lack of initiative drive; anhedonia, lack of pleasure in life. Some of these then will start overlapping with a depressive disorder.

But also, then, adaptive functioning deficits are in practical domain, such as grooming, self-care. Then difficulties in life functioning, occupational relationships, for example.

Q. So these negative symptoms, for example, blunted affect, alogia -- did I pronounce that right?

A. Well, I think it's alogia.

Q. Alogia?

A. Yeah.

Q. How are those -- how is that even possible that

those things could be confused with, for example, poor effort in testing?

A. Well, alogia is going to be a lack of spontaneous speech conversation. The avolition is just, again, a lack of initiative, motivation, response. Again, disengagement, spontaneity, but motivation, you know. And the effort tests are motivation. Like, we're looking at the motivation effort.

So, you know, when you have these negative symptoms, that is part of the problem when we're doing this type of effort testing. There's often thought blocking consistent with schizophrenia, which is a delay in responses because of difficulties with processing. Things going on in one's mind that we may not know about where they're trying to process information, they may be hearing things or hearing delusions or strange thought processes that are cognitive, I would say, deficiencies with schizophrenia.

Q. So do antipsychotic medications necessarily treat all the negative symptoms of schizophrenia?

A. Well, some -- so the person may have a medication to really assist with the voices or delusions, and then another medication may assist with the negative symptoms as well.

Q. But sometimes those aren't the same medication?

A. Correct.

Q. So sometimes the negative symptoms of schizophrenia can persist even if the positive symptoms, the hallucinations, have been dealt with?

A. Yes.

Q. But those negative symptoms could also cause problems with --

A. Correct.

Q. -- competency?

A. And --

Q. Is that fair?

A. Fair. And the medications may cause a person to be sedated which can affect cognition and motivation.

Q. So what's the relationship between effort, motivation, intellectual disability, and schizophrenia?

A. Wow. It's complicated. So -- well, there's a lot of relationships. I can give you a zillion ways that could affect -- I guess they're separate disorders. When they're together, they're most profound.

As I said in your manual over there, together they're going to place an individual at highest risk to fail effort tests than just one condition alone. So all of those conditions can affect effort, which ultimately can affect your testing and your results even, let's say, an IQ test.

I would -- well, that leads to: What's your best practice? When do you administer these tests? Okay. So do you want to administer them when they're on certain medications? Do you want to wait? There's different ways to look at that synopsis there.

Q. Okay. Should I go back to Slide 104?

A. Well, the lower a person's cognitive functioning and the more significant the symptoms of schizophrenia, the more likely they'll fail effort.

Q. What about schizophrenia and competency to stand trial?

A. That's the number one disorder that is found to be amongst folks that were found to be incompetent by far. So, really, it lends itself to the Dusky standard, because many folks with schizophrenia are not rational. So they will have difficulties in making rational legal decisions, as far as pleas, and also as to how they communicate and think and assist with you.

So those are kind of the two -- they often understand their charges and penalties, that's the easy stuff. The meat is: How are they going to assist their defense in their defense? And when are their legal decisions going to be made? You know, are they making logical, rational legal pleas in their decisions when you talk about the evidence? You know, how they want to

handle their case?

As well as whether they appreciate that they have mental illness and appreciate an important legal safeguard as to insanity. So that defense, if they lack insight, which is very common with folks with schizophrenia, as you know, they don't think they're mentally ill. They don't think there's any connection with mental illness to the crime, and they will not plead insane because they don't think they're mentally ill.

If he has a viable insanity defense, then they may not be competent to stand trial because they're not appreciating that legal defense.

Q. Dr. Fabian, if you have a case that involves potentially three of these syndromes; intellectual disability, autism, and schizophrenia, how are people supposed to figure out what causes the incompetence?

A. There are a lot of cooks in the kitchen, I'll start with that. So you've got different examiners in different facilities doing different things.

So if I may, I -- you know, a judge from Indianapolis called me the other day and said, We need you to do an Atkins evaluation, and he needs it lickety-split. I'm like, Well, you need to talk to the other experts. There's a prosecutor expert, a defense expert, and I'm your expert.

So there's different ways to do this IQ. And I've done it with a prosecutor expert or a defense expert. I've done it on my own. We don't want to do the same test quick, like, with a practice effect. So that's rule one. You would need to communicate on what people are doing, if you can. He told me, he said, the Defense expert already did the WAIS-5. I'm not doing it. I may not do an IQ test. It was valid then. So we don't need me to reinvent that wheel.

So there's communication about what's going on. Your question -- and I get it, and I don't want to do a narrative. There's so many things I can answer.

So what do we do with someone who has suspected schizophrenia, ID, ASD who's on medications, is related to evaluating him for competency to stand trial?

Q. Yes. My question to you is: If somebody has those three co-occurring problems, right, what are the best practices for trying to sort it out?

A. Well, as an examiner, no matter who is retaining you, we want to look to see if -- we want to look at their records first, okay. We want to see what their diagnoses are, what their history is, okay? Is this the first time they've had schizophrenia, psychotic symptoms following the offense? Was it present before? Things of that nature.

We're also looking at what medications maybe they're on historically now. Do they help the condition? We want to look at school records to see, you know, how they functioned historically, if we have school records.

If I'm on an inpatient unit, I want to see how they're getting along with their presentation is are they -- just observations of that person in that facility because it's hard to fake long term in a facility being watched and, you know.

So we want to look at their criminal record. A lot of things we want to look at kind of before we -- that's what we start with. Then we start with the assessments. Knowing that this -- well, you know, I can understand that if you're thinking the person is low functioning, you want to start, really, with an effort test and then -- I typically start with that, and then give an intelligence test, okay or whatever reading test, let's say, you know, but I want to see how their effort is, you know.

I've seen it different ways, Your Honor, where when I was in my fellowship if we -- we had a neuropsychological battery and it could be brain cancer, it could be a tumor, it could be epilepsy, a seizure, a stroke, a TBI, ID, and if they failed effort, we still did the battery, okay?

And any strength -- any average or above average, we knew that was their ability. Anything below, we didn't know if that was an impairment or not, but some other people look at it as if you fail, then you don't continue with testing. We're not sure if it's valid.

The problem is, you can do that if it's a clear kind of malingerer, right? But in this type of case, sure, if you suspect that they're cognitively delayed or impaired, you can do the testing. I would suggest you do the effort testing before you do IQ, okay.

You have to be careful about whether they are -- where their functioning is to really do the M-FAST, for example, and really maybe not do it if it's really not normed on that population, okay? Or if you come to court, you have to testify to the limitations of that instrument with that particular population.

So I would look to see what their prior diagnoses are to be able to figure out what test you may or may not want to do with that person. So when you evaluate him, you may not know, Hey, this guy is ID. I should not use this test, because you may have to figure out if they're ID.

Q. So for all three in sorting it out, it's records from history, collateral interview, testing; is there anything else?

A. Well, I also -- I mean, I typically will -- now often I will get a call, and they say, Do everything; competency, sanity, mitigation, Atkins, the whole thing, but there's different experts at different times as well.

So -- (indiscernible) doing competency -- the other night, I didn't do an IQ test, and it was a rape case that I referenced. I didn't do an IQ test. Now, I do have a 5-8 -- 58 before. I didn't have it with me. It was in the gentleman's health records. I don't know if that was true or not.

So I didn't do an IQ test, and I'm recommending he's not competent to stand trial. I didn't need to do an IQ test to know that he was not -- that I believed he was not competent, okay.

Q. That's fair.

One financial question: Is it scientifically valid to give the WAIS twice in a three-month period?

A. No.

Q. Why not?

A. Practice effects of -- the AAIDD will say a year depending on the research study and the subtest, there's more practice effects in tests that you do -- you get practice on. So let's say block design. Oh, I remember those blocks, that's right.

So the other day my psychometrist who does a lot

of my testing, she said -- he was at the office, the defendant. I had met him before. He said, I recognize the blocks. We don't do it. I've got another IQ test I'll do or I'll just get him to sign a release and I'll get that IQ score. So you have to kind of ask questions before you do, especially in these types of cases, but three months, that's a problem.

MS. RUSSELL: Okay. I think we're done now, Dr. Fabian. Thank you.

THE WITNESS: Thank you.

THE COURT: Thank you.

Any cross-examination?

MS. SULLIVAN: Yes.

CROSS-EXAMINATION

BY MS. SULLIVAN:

Q. Hi, Dr. Fabian.

A. Hi.

Q. You were hired by the Public Defender's Office?

A. Yes.

Q. Is that right?

A. Yes.

Q. Do you charge by the hour? What was your fee schedule with them?

A. Yeah, by the hour is 350.

Q. Okay. How many hours would you say you've put

into this?

A. Like probably before today, a dozen.

Q. Okay. Did that consist of generating this PowerPoint we've been watching?

A. Yeah.

Q. And you live in Austin, Texas; is that right? Did I catch that? Or where do you live?

A. I live in Austin. Yeah, I live there primarily. I'm here as well sometimes. I am joining this trip with a case that I'm driving to today.

Q. Okay. I'll be a little clearer.

Where did you fly from to get here?

A. Austin.

Q. Okay. And that will be paid for as well by Defense counsel?

A. Yeah.

Q. Okay. I just want to be clear. We've talked a lot about different mental illnesses and intellectual disability and IQ testing. You've never evaluated Thomas Mosley, right?

A. That is correct.

Q. You've never met him other than he's in the courtroom here today, correct?

A. Yes. I don't know him.

Q. You haven't diagnosed him with any, if any,

mental illness?

A. Nothing.

Q. You haven't conducted any testing on Mr. Mosley.

A. I have not.

Q. You do not have an opinion as a doctor regarding his competency to stand trial?

A. I do not.

MS. SULLIVAN: May I have a moment?

THE COURT: Yes.

MS. SULLIVAN: Nothing further. Thank you.

THE COURT: Any redirect?

MS. RUSSELL: No, Your Honor.

THE COURT: Thank you for your time. Would you all mind e-mailing me a copy of this? That way, I'm not taking something out of evidence and copying it. I'm just going to hand it off to the clerk for filing, and that way, I will have a copy for my notes. If that's okay, that would be great.

MS. RUSSELL: Sure.

THE COURT: Did you have a chance to look at this motion?

MS. SULLIVAN: I was given it when I walked in here this afternoon. I want to talk to Dr. Railey. My understanding is that Dr. Railey has turned over everything that he had that wasn't proprietary. I

need to talk to him. I need a moment because I just got handed this --

THE COURT: That's fine. I'm not -- that's why I'm asking if you had a chance to look at it. If you're not prepared to discuss it today, we won't do it today. We have other hearings coming up, not next week, but the week after.

So who do you want them provided to, you or another doctor?

MS. RUSSELL: Us.

THE COURT: Okay.

MS. RUSSELL: The story is, Your Honor, the WHODAS, as it turns out, is open source. The manual --

THE COURT: Right.

MS. RUSSELL: -- is in my hand right here. I got it off the Internet. We don't really believe the materials are proprietary.

THE COURT: Okay.

MS. RUSSELL: And we would like to see those score sheets because there are some real discrepancies in both the time and the method of his having given it to Mr. Mosley.

THE COURT: So let's --

MS. RUSSELL: The broad -- he did provide it to

our experts, but our expert is saying that, you know, even though we've had a long discussion with her, in deference to Dr. Railey's deeming those materials proprietary, she said, I will need a Court order in order to show you those tests.

THE COURT: Okay. So let's do this. Next week, let's come in preferably on the 2nd, if that works for everybody.

MS. SULLIVAN: I'm not here next week. I'm at a conference. I'm also -- can we -- I just want to clarify.

Your doctors have whatever it is you're asking for, right?

MS. RUSSELL: I'm just asking the Court to let me look at it because normally that would be -- if it were proprietary -- for example, if it were the WAIS or the WAIS score sheet --

THE COURT: Right.

MS. RUSSELL: -- it would be proprietary.

THE COURT: No, I understand.

MS. RUSSELL: We would have to do it under seal and all of that kind of stuff.

THE COURT: Got it.

MS. RUSSELL: But because this is open source, Dr. Railey did provide the bubble sheet right to our

expert who has it. It is not really an interpretative test where someone would be scoring. It's basically, like, yes, maybe, no. So it's not something that's really subject to sort of psychological interpretation. It's pretty easy for somebody like us to interpret.

Because of some of the discrepancies about what Dr. Railey said in his report and what is on that score sheet, and because of the difficulty with us talking to our experts. Basically, we've talked to our expert about it and she's telling me on the phone, Well, then they circle here.

I mean, it's practically impossible to do it without actually seeing the sheet. And if it's impossible for me to do it without seeing the sheet, it's also going to be impossible for the Court to understand it without a sheet and to be in the appellate record.

THE COURT: Okay.

MS. RUSSELL: So our position is, we would just like our neuropsychologist to be able to produce that to us, so we can actually look at the thing.

THE COURT: Okay.

MS. RUSSELL: Be a little bit more specific in our cross-examination of Dr. Railey.

THE COURT: Okay. So when can you have an answer, and when can you come to Court and tell me what that answer is?

MS. SULLIVAN: But you're -- I just have a question.

THE COURT: I'm not going to rule on the motion today.

MS. SULLIVAN: Okay.

THE COURT: I want to give you an opportunity to look into whatever you want to look in. I'm just asking when you can give me an answer on whether or not you're agreeing or when we could have a motion.

MS. SULLIVAN: Can I ask a few questions of Defense, though?

THE COURT: Of course you can.

MS. SULLIVAN: So Dr. McClain doesn't want to turn that over without a Court order to you?

MS. RUSSELL: Correct.

MS. SULLIVAN: Because is she having concerns that it's --

MS. RUSSELL: No, because, again --

THE COURT: Her concern is because Dr. Railey said it was proprietary.

MS. SULLIVAN: Okay. So I just want to know what -- I can talk to Dr. Railey about it, but if

you're just wanting the Court to do an order, it's not really me, then, going back because he's turned over whatever it is.

MS. RUSSELL: Right. He's already given it to her. And she, I think, would say that it's probably not proprietary because we all picked -- it's not really that test security --

THE COURT: You need clarification from Dr. Railey --

MS. SULLIVAN: Yes.

THE COURT: -- about whether it's proprietary?

MS. SULLIVAN: Well, also from Mr. McClain. It sounds like she has concerns, too.

MS. RUSSELL: No. I'm saying I don't think she has concerns.

MS. SULLIVAN: You don't think she does?

MS. RUSSELL: Right, because her basic thing is that she's trying to be respectful of Dr. Railey because he's considering it to be proprietary.

For the record, he said that he gave the questions orally to Mr. Mosley while I was sitting there, and then he asked me to leave when he gave the WAIS. So he also said many things during the exam, but he didn't think it was proprietary, and he didn't care, he was going to ask the questions while I sat

there. So again --

MS. ELLIS: (Indiscernible.)

THE COURT: What day do you want to come in and have a motion, then? In the meantime, if you agree to it, fine, but if you want to have a motion, you should do it, obviously, before Dr. Railey testifies.

Dr. Railey is scheduled to testify on Thursday the 10th. So I can even do July 7th, which is Monday.

MS. SULLIVAN: Ms. Ellis says she can come in next week, so you're not waiting on me. I mean, I'm the -- it's fine. We can argue about it later. I don't want to go back and forth, but it sounds to me like Dr. Railey is going to say it is proprietary, so I don't really know how we're going to get anywhere other than you just deciding if you're going to order them to turn it over.

THE COURT: I would like to know the answer. Dr. Fabian just told us it's open source and not proprietary, so I would like to hear what Dr. Railey has to say about that. I'm not --

MS. ELLIS: I'll give him a call to clarify.

THE COURT: July 2nd, please.

MS. ELLIS: Okay.

MS. RUSSELL: Sure. Can I --

THE COURT: That way, they have enough time, if it's going to get looked at to --

MS. RUSSELL: Can I just add one thing?

THE COURT: Of course.

MS. RUSSELL: In the past, we also have actually gotten into the raw data in the WAIS -- and I'm not saying we're going to do this in this case, but we basically close the courtroom, put the thing up, then file it under seal. Because sometimes the actual proprietary data is important, and it's important for it to be an exhibit, and for it to be entered into the record. I think that, actually, this data is going to end up being important in this analysis.

THE COURT: Okay.

MS. RUSSELL: And I think that this Court and the appellate court and, you know, for time and memorial in that 3.851, they're going to need to see it even under seal.

THE COURT: We'll have that motion July 2nd and talk about it. So set it for July 2nd, and also set it, Madam Clerk, for pretrial so Mr. Mosely is brought up, and we'll need a court reporter for that day as well. Okay?

MS. ELLIS: Are they going to file a motion, or this was your oral motion to do that?

MS. RUSSELL: We filed the motion today.

MS. ELLIS: For the WAIS data, too?

MS. RUSSELL: No. No. We're not asking for the WAIS. We --

THE COURT: I'm only hearing the Motion to Compel on Tuesday.

MS. ELLIS: Okay. All right. I will see you all next week, then.

(Hearing was concluded.)

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF PINELLAS)

I, CHARLENE M. EANNEL, RPR, Stenographic Court Reporter, certify that I was authorized to and did stenographically report the foregoing proceedings and that the transcript is a true record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 1st day of July, 2025.

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CHARLENE M. EANNEL, RPR