No. 15-65

IN THE

Supreme Court of the United States

JUAN LIZCANO,

Petitioner,

v.

TEXAS,

Respondent.

On Petition for a Writ of Certiorari to the Court of Criminal Appeals of Texas

BRIEF OF *AMICI CURIAE*, THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (AAIDD), AND THE ARC OF THE UNITED STATES, IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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INTEREST OF *AMICI*

Amici are scientific, clinical, and voluntary organizations in the field of intellectual disability.

THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (AAIDD) (formerly named the American Association on Mental Retardation), founded in 1876, is the nation's oldest and largest organization of professionals in the field of intellectual disability (mental retardation). Primarily focused on clinical, psychological, scientific, educational, and habilitative issues, AAIDD also has a longstanding interest in legal issues that affect the lives of people with intellectual disability. AAIDD has appeared as *amicus curiae* in this Court in a variety of cases involving mental disability, including *Atkins v. Virginia*, 536 U.S. 304 (2002). AAIDD has formulated the most widely-accepted clinical definition of intellectual disability, as noted by this Court in *Atkins*, 536 U.S. at 308 n.3. *See* AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2010). Both as the formulator of the clinical definition of intellectual disability and as an interdisciplinary membership organization concerned with maintaining appropriate professional standards in the diagnosis of intellectual disability, AAIDD and its members have a strong interest in the manner in which *Atkins* claims are evaluated by courts.

THE ARC OF THE UNITED STATES ("The Arc"), founded in 1950, is the nation's largest community-based organization of and for people with intellectual and developmental disabilities and consists of nearly 700 state and local chapters across the country. The Arc promotes and protects the human and civil rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes. Through its National Center on Criminal Justice and Disability, The Arc serves as a national clearinghouse for information, training, and advocacy on the topic of people with intellectual and developmental disabilities involved in the criminal justice system. The Arc has a vital interest in ensuring that all individuals with intellectual and developmental disabilities receive the protections and supports to which they are entitled by law and that courts and administrative agencies employ commonly accepted scientific principles for the diagnosis of intellectual and developmental disabilities. The Arc has appeared as *amicus curiae* in this Court in a variety of cases involving intellectual and developmental disabilities, including *Atkins v. Virginia*, 536 U.S. 304 (2002), and *Hall v. Florida*, 134 S. Ct. 1986 (2014).

SUMMARY OF ARGUMENT[1]

The definition of intellectual disability (often abbreviated ID) has been designed to encompass people who have very low scores on intelligence tests and who also have substantial limitations in their adaptive skills. Diagnosticians measure the former with IQ tests, and the latter with determination of the *deficits* the individual experiences in everyday living. This formulation of the definition has been studied and evaluated by scholars and clinicians for decades and is universally accepted by scientific and clinical organizations.

In implementing this Court's decision in *Atkins v. Virginia*, Texas has essentially replaced the clinical definition's carefully crafted requirements with a formula of its own devising, one that rests heavily on stereotypes about people with intellectual disability. This approach is inconsistent with accepted clinical standards.

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[1] This brief was written entirely by counsel for *amici*, as listed on the cover. No counsel for either party authored this brief in whole or in part, and neither counsel for a party nor any party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the members of the organizational *amici* or their counsel made a monetary contribution to the preparation or submission of this brief. All parties were notified in a timely manner of the intent to file this brief, and have given written consent to its filing. These documents have been filed with the Clerk's Office.

ARGUMENT

In *Atkins v. Virginia*, 536 U.S. 304 (2002), this Court held that the Cruel and Unusual Punishments Clause of the Eighth Amendment forbids the execution of any individual who falls within the clinical definition of intellectual disability (or, previously, "mental retardation").

The definition of intellectual disability consists of three requirements: reduced intellectual functioning (as measured by IQ testing), impairment in adaptive skills, and onset of the disability before the individual became an adult.[2] In *Hall v. Florida*, 134 S. Ct. 1986 (2014), this Court addressed the first prong of the definition—the requirement of significant limitations in intellectual functioning—and noted that the clinical definition of intellectual disability was "a fundamental premise of *Atkins*." *Id.* at 1999.

This case involves the second prong of the definition: the diagnostic requirement that an individual have "significant limitations . . . in adaptive behavior."[3] There is a substantial,

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[2] American Association on Intellectual and Developmental Disabilities (AAIDD), *Intellectual Disability: Definition, Classification, and Systems of Supports* 5 (11th ed. 2010) ("Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.").

[3] Over the years, the precise language used to describe the adaptive behavior (sometimes abbreviated as AB) prong has varied somewhat, reflecting advances in clinical understanding

consistent, and robust body of clinical and scientific literature on the meaning and application of this requirement.

I. The Clinical Requirement of Adaptive Deficits.

For decades, the clinical definition of intellectual disability has required a determination that the individual has, in addition to limitations in intellectual functioning, deficits in adaptive functioning.[4] This requirement reflects the consensus among clinicians and professional organizations in the field that "intellectual limitation

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and practices. But these changes in terminology have not altered the concept of adaptive behavior or altered the category of individuals who are found to have significant deficits. *See* AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 11 (11th ed. 2010) ("[B]oth the definition of ID and its operationalization have remained consistent over time."). State statutes also vary in their terminology regarding adaptive behavior, having been adopted at different times and incorporating language derived from different iterations of the definition. All of these statutory definitions are grounded in clinical understanding, and encompass the same set of individuals.

[4] *See, e.g.*, American Association on Mental Deficiency, *A Manual on Terminology and Classification in Mental Retardation* 3 (2d ed. 1961) (subaverage intellectual functioning "is associated with impairment in adaptive behavior"). For a discussion of the evolution of the adaptive behavior component, see Kazuo Nihira, *Adaptive Behavior: A Historical Overview*, in *Adaptive Behavior and Its Measurement: Implications for the Field of Mental Retardation* 7, 7-14 (Robert L. Schalock ed., 1999).

is a necessary but not a sufficient condition for mental retardation." Anne Anastasi & Susana Urbina, *Psychological Testing* 248 (7th ed. 1997). The purpose of this component of the definition is to exclude from the diagnosis any individual whose low performance on IQ testing is not accompanied by a substantially disabling impairment of functioning in life.[5] Put another way, the adaptive behavior

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[5] AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 43 (11th ed. 2010) ("Adaptive behavior is the collection of conceptual, social, and practical skills that have been learned and are performed by people in their everyday lives."). The American Psychiatric Association's classification manual similarly requires:

> Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 33 (5th ed. 2013). The American Psychological Association recognizes the same diagnostic requirement. *See* Keith F. Widaman & Kevin S. McGrew, *The Structure of Adaptive Behavior*, in American Psychological Association, *Manual of Diagnosis and Professional Practice in Mental Retardation* 97, 97 (John W. Jacobson & James A. Mulick eds., 1996) ("To be identified as having [mental retardation], a person must exhibit both significantly subaverage intelligence and deficits in adaptive behavior during the developmental period."); *id.* ("Adaptive behaviors are the behavioral skills that people typically exhibit when dealing with the environmental demands they confront.").

requirement is designed to restrict the diagnosis of intellectual disability to those individuals who, in addition to their low IQ scores, also have an actual, significant disability. Thus, it excludes people who are merely very poor test-takers.[6]

The Diagnostic Focus on Deficits

The clinical definition of adaptive behavior has long focused exclusively on adaptive *deficits*.[7] As a

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[6] Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124, 132 (2009) ("Even a very low score on a single measure of general intellectual functioning is never sufficient.").

[7] *See, e.g.*, AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 1 (11th ed. 2010) ("significant *limitations* . . . in adaptive behavior"); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 33 (5th ed. 2013) ("*[d]eficits* in adaptive functioning"); American Psychological Association, *Manual of Diagnosis and Professional Practice in Mental Retardation* 13 (John W. Jacobson & James A. Mulick eds., 1996) ("significant *limitations* in adaptive functioning"); American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992) ("*limitations* in . . . adaptive skill areas"); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 32 (3d ed. rev. 1987) ("[c]oncurrent *deficits or impairments* in adaptive functioning"); American Association on Mental Deficiency [now AAIDD], *Classification in Mental Retardation* 11 (rev. 1983) ("*[d]eficits* in adaptive behavior"); American Association on Mental Deficiency, *Manual on Terminology and Classification in Mental Retardation* 11 (rev. 1973) ("existing concurrently with *deficits* in adaptive behavior"); American Association on Mental Deficiency, *A Manual on Terminology and Classification in Mental Retardation* 3 (2d ed. 1961) ("Mental retardation refers to subaverage general intellectual functioning which originates

result, each diagnostic evaluation explores and documents those things that an individual *cannot* do in everyday life.[8] In the absence of such practical

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during the developmental period and is associated with *impairment* in adaptive behavior.") (emphasis added in each quotation).

[8] Clinicians have developed sophisticated and detailed methods for objectively answering the question of what deficits or limitations an examined individual may have. These methods include, but are not limited to, psychometric instruments known as adaptive behavior scales. *See* J. Gregory Olley, *Adaptive Behavior Instruments*, in *The Death Penalty and Intellectual Disability* 187, 187-200 (Edward A. Polloway ed., 2015); Sharon A. Borthwick-Duffy, *Adaptive Behavior*, in *Handbook of Intellectual and Developmental Disabilities* 279, 283 (John W. Jacobson, James A. Mulick & Johannes Rojahn eds., 2007) ("The development in the past 20 years of psychometrically adequate, norm-referenced measures of adaptive behavior has led to a greater recognition of the value of [adaptive behavior] in diagnosis and planning supports."). The major professional organizations with an interest in intellectual disabilities have recognized the importance of these diagnostic instruments. *See, e.g.*, AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 47 (11th ed. 2010) ("Significant limitations in adaptive behavior are established through the use of standardized measures . . . ."); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 37 (5th ed. 2013) ("Adaptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures."); Marc J. Tassé et al., *The Construct of Adaptive Behavior: Its Conceptualization, Measurement, and Use in the Field of Intellectual Disability*, 117 Am. J. on Intellectual & Developmental Disabilities 291, 293 (2012) ("Various groups in addition to AAIDD have recommended the use of standardized measures of adaptive behavior to assess the second prong of the definition of ID. For example, in 1996, Division 33 of the American Psychological Association recommended the use of a comprehensive,

deficits, clinicians cannot diagnose the individual as having intellectual disability. The clinician's diagnostic focus does not involve any form of "balancing" deficits against the abilities or strengths which the individual may also possess.

Framing the adaptive behavior element in terms of a person's limitations was not an arbitrary choice in the formulation of the definition of intellectual disability. While the diagnostician's singular focus on adaptive deficits (as contrasted to balancing strengths and weaknesses) might initially seem counterintuitive to many laypeople, it makes clinical sense in the diagnostic process because the second prong's function is to ascertain whether the measured *intellectual* limitations (i.e., the first prong) have real-world consequences in the individual's life.[9]

This focus on adaptive deficits is essential to the diagnostic process because clinicians universally recognize that, in the lives of individuals with intellectual disability, weaknesses in functioning almost always co-exist with relative strengths. As the AAIDD classification manual explains, the finding of "significant limitations in conceptual, social, or practical adaptive skills is not outweighed

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individual measure of adaptive behavior to allow objective assessment of significant limitations in adaptive behavior in comparison to the general population.") (citation omitted).

[9] *See Hall v. Florida*, 134 S. Ct. at 2001 ("Intellectual disability is a condition, not a number.").

by the potential strengths in some adaptive skills."[10] As a result, the existence of one or more adaptive strengths cannot negate a diagnosis of intellectual disability.[11]

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[10] AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 47 (11th ed. 2010). This fact has long been recognized by clinicians. *See, e.g.*, American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992) ("Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities . . . ."). *See also* Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 220 (2009) ("[A]ll individuals with intellectual disability typically demonstrate strengths in functioning along with relative limitations."); Caroline Everington & Denis W. Keyes, *Diagnosing Mental Retardation in Criminal Proceedings: The Critical Importance of Documenting Adaptive Behavior*, 8 The Forensic Examiner, July/August 1999, at 31, 32 ("adaptive limitations often coexist with strengths in other adaptive skills and personal capabilities").

This Court has recognized this key aspect of the definition of intellectual disability. *See Brumfield v. Cain*, 135 S. Ct. 2269, 2281 (2015) ("[I]ntellectually disabled persons may have 'strengths in social or physical capabilities, strengths in some adaptive skill areas, or strengths in one aspect of an adaptive skill in which they otherwise show an overall limitation.'") (quoting American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 8 (10th ed. 2002)).

[11] While it is often important for clinicians to identify and assess a person's strengths and skills for purposes of planning and implementing individualized educational and habilitative programs, those strengths play no role in the *diagnostic* determination of whether the person meets the definition of intellectual disability. J. Gregory Olley, *The Death Penalty, the Courts, and Intellectual Disabilities*, in *The Handbook of High-*

Clinical diagnostic standards focus on *deficits* in adaptive functioning because practically every individual who has intellectual disability also has things that he or she has learned to do, and can do.[12] The functional impairments and adaptive deficits that are experienced by people with intellectual disability are not uniform across the class, and the diagnostic standards cannot and do not require such uniformity.[13]

Risk Challenging Behaviors in People with Intellectual and Developmental Disabilities 229, 233 (James K. Luiselli ed., 2012) ("[I]t is important to note that a clinical evaluation emphasizes strengths in order to plan services that capitalize upon those strengths to promote success. An evaluation for the court is focused on deficits because its purpose is to determine a diagnosis, and an ID is, by definition, a condition characterized by deficits.").

[12] *See, e.g.*, Caroline Everington, *Challenges of Conveying Intellectual Disabilities to Judge and Jury*, 23 Wm. & Mary Bill Rts. J. 467, 471 (2014) ("Interpretation of these findings requires an understanding of typical behavioral expectations of individuals who function in the mild range of ID. For example, the presence of a defendant's strengths in some areas, such as having a history of steady employment or possessing academic skills in the fourth to sixth grade range, is to be expected and does not preclude a diagnosis of ID.").

[13] J. Gregory Olley, *The Death Penalty, the Courts, and Intellectual Disabilities*, in *The Handbook of High-Risk Challenging Behaviors in People with Intellectual and Developmental Disabilities* 229, 233 (James K. Luiselli ed., 2012) ("[P]eople with mild ID are a heterogeneous group with individual profiles of relative strengths and weaknesses. One cannot argue that the presence of a particular strength rules out ID, particularly if it is a strength shared with others with ID.").

This degree of diversity among people who have intellectual disability is often unappreciated or unknown by laypeople who have limited experience with the disability.

Stereotypes About People with Intellectual Disability

There is a wide gap between the clinical definition, on the one hand, and the impressions and expectations of many laypersons about what intellectual disability (or mental retardation) means. The magnitude of that gap and its consequences can be particularly problematic. As a prominent leader in the field of intellectual disability has observed,

> Most individuals with mental retardation will have strengths and areas of ability. These strengths may confound a layperson or a professional with limited clinical experience with individuals who have mild mental retardation. These laypersons may erroneously interpret these pockets of strengths and skills as inconsistent with mental retardation because of their misconceptions regarding what someone with mental retardation can or cannot do.

Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 121 (2009) (citation omitted).

Such preconceived assumptions about what it means for someone to have an intellectual disability often contrast sharply with the understanding of professionals and clinicians in the field.[14] Some of these stereotyped notions are triggered by an individual's physical appearance,[15] but many are also

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[14] People with intellectual disability have confronted popular misunderstanding and stereotypes throughout our history. *See* James W. Trent, Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* 131-224 (1994). In the past, many of these stereotypes gave rise to egregious legislation, particularly at the state level. For example, a 1929 Michigan statute provided, "It is hereby declared to be the policy of the state to prevent the procreation and increase in number of feeble-minded, insane and epileptic persons, idiots, imbeciles, moral degenerates and sexual perverts, likely to become a menace to society or wards of the state. The provisions of this act are to be liberally construed to accomplish this purpose." Act of May 22, 1929, No. 281, § 1, 1929 Mich. Pub. Acts 689, 689-90.

[15] *See* J. Gregory Olley, *The Death Penalty, the Courts, and Intellectual Disabilities*, in *The Handbook of High-Risk Challenging Behaviors in People with Intellectual and Developmental Disabilities* 229, 231 (James K. Luiselli ed., 2012) ("[T]he public generally misunderstands mild ID and expects that such individuals are easy to identify by their physical appearance, their speech, or other readily apparent characteristics."); AAIDD, *User's Guide: Intellectual Disability: Definition, Classification, and Systems of Supports* 25-26 (2012) ("Physical appearance can also contribute to stereotypes as reflected in the statement that 'if you don't have the look (as in Down Syndrome) then you are not intellectually disabled.' It should be noted that the vast majority of persons with an ID have no dysmorphic feature and generally walk and talk like persons without an ID."); Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 220 (2009) ("Most of these individuals [in the range of mild intellectual disability] are

based on the public's often-uninformed expectations about what people with intellectual disability supposedly can and cannot do. There is a strong impulse to conjure up our own vision of what people with mental retardation are like, and then to evaluate individuals by how closely they resemble our preconceived image of mental retardation.[16]

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physically indistinguishable from the general population because no specific physical features are associated with intellectual disability at higher [IQ levels].").

[16] *See, e.g.*, Marcus T. Boccaccini et al., *Jury Pool Members' Beliefs About the Relation Between Potential Impairments in Functioning and Mental Retardation: Implications for Atkins-Type Cases*, 34 Law & Psychol. Rev. 1, 18 (2010); Andrea D. Lyon, *But He Doesn't* Look *Retarded: Capital Jury Selection for the Mentally Retarded Client Not Excluded After Atkins v. Virginia*, 57 DePaul L. Rev. 701, 712 (2008) ("Many mistakenly believe that one can merely look at a person and tell whether he is mentally retarded."); Joanne Kersh, *Attitudes About People with Intellectual Disabilities: Current Status and New Directions*, in 41 *International Review of Research in Developmental Disabilities* 199, 220 (Robert M. Hodapp ed., 2011) ("Additionally, a lack of familiarity with people with ID may lead to a reliance on common misperceptions and stereotypes in order to make judgments and decisions about individuals.").

It is also clear that stereotypes about intellectual disability are often based on images of people with more severe or profound levels of impairment than those individuals who are most frequently encountered in capital cases. Stephen Greenspan, *The Briseno Factors*, in *The Death Penalty and Intellectual Disability* 219, 221 (Edward A. Polloway ed., 2015). *See* Gilbert S. Macvaugh III & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 142 (2009) ("[V]irtually all [capital offenders with mental retardation] are within the mild category of mental retardation."); Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental*

These lay assumptions often include an imagined "list" of things that people with intellectual disability cannot do. The characteristics that are supposedly inconsistent with intellectual disability can involve, for example, employment, social relationships, and driving a car. But the clinical literature is abundantly clear that many of the people who have been properly diagnosed with intellectual disability can perform one or more of these tasks.[17]

Retardation, 16 Applied Neuropsychology 124, 125 (2009) ("Death penalty appeals involving claims of MR . . . virtually always involve [mild mental retardation].").

[17] *See, e.g.*, Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124, 133 (2009); Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 220-21 (2009); Roger J. Stancliffe & K. Charlie Lakin, *Independent Living*, in *Handbook of Developmental Disabilities* 429, 430 (Samuel L. Odom et al. eds., 2007) ("Seminal studies have documented the ability of many people with ID to live reasonably successfully in the community with relatively modest formal support . . . .") (citations omitted); Gary N. Siperstein & Melissa A. Collins, *Intellectual Disability*, in *The Death Penalty and Intellectual Disability* 21, 26-27 (Edward A. Polloway ed., 2015); David Mank, *Employment*, in *Handbook of Developmental Disabilities* 390, 392 (Samuel L. Odom et al. eds., 2007); Michael L. Wehmeyer & Susan B. Palmer, *Adult Outcomes for Students with Cognitive Disabilities Three-Years After High School: The Impact of Self-Determination*, 38 Education & Training in Developmental Disabilities 131, 139-40 (2003); *see also* Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 38-39 (2d ed. 2014).

The scholarly literature provides no support for such an exclusionary list of everyday tasks incompatible with a diagnosis of intellectual disability. Nor is there such a list in the experience of clinicians who deal with individuals with intellectual disability every day.

II. Texas Has Altered the Accepted Clinical Definition of Adaptive Behavior with Its Own List of Stereotypes About People with Intellectual Disability.

The definition of intellectual disability consists of carefully calibrated requirements of limited intellectual ability and deficits in adaptive functioning. Deviation from either of the definition's components substantially undermines the validity and reliability of the diagnostic process.

Texas instructs its courts to evaluate defendants by a list of characteristics that it deems incompatible with a diagnosis of intellectual disability. *Ex parte Briseno*, 135 S.W.3d 1, 8-9 (Tex. Crim. App. 2004). These so-called "factors" focus primarily on supposed strengths, such as planning ability, responding rationally, and dissembling. This approach violates the basic diagnostic principle that the second prong focuses on *deficits* rather than strengths or abilities.[18]

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[18] In the same opinion, Texas nominally accepted a clinically-based definition of intellectual disability, but promptly added a list of purportedly diagnostic factors of its own invention. *Briseno*, 135 S.W.3d at 7-8.

The distortion of the definition with invented factors is fundamentally inconsistent with the clinical understanding of intellectual disability, and has no support in the scientific and clinical literature in the field. It has been severely criticized by scholars and practitioners who study and work with people with intellectual disability.[19]

The Texas factor that is most clearly at odds with the clinical literature concerning the diagnosis of intellectual disability is the final one in the list: whether the facts of the crime were consistent with a diagnosis of mental retardation. This approach focuses on purported strengths, and has been explicitly rejected by clinical experts.[20]

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[19] *See, e.g.*, Gilbert S. Macvaugh III & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 136 (2009) ("The seven criteria of the *Briseno* opinion operationalize an *Atkins* interpretation that only exempts a subcategory of persons with mental retardation from execution.") (The Macvaugh and Cunningham article is an outgrowth of the ad hoc committee on *Atkins* evaluations within the relevant section of the American Psychological Association.); Caroline Everington, *Challenges of Conveying Intellectual Disabilities to Judge and Jury*, 23 Wm. & Mary Bill Rts. J. 467, 481 (2014) ("Using these seven factors as part of a diagnosis has the potential (if strictly interpreted) to exclude anyone functioning in the mild ID range from the protection of *Atkins*."); Stephen Greenspan, *The Briseno Factors*, in *The Death Penalty and Intellectual Disability* 219, 219 (Edward A. Polloway ed., 2015) ("Few if any intellectual disability (ID) scholars, representative bodies, or specialists consider that the Briseno factors provide a valid diagnostic framework.").

[20] *See, e.g.*, Gilbert S. Macvaugh III & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 169 (2009)

Under professional standards, diagnosticians are not free to replace the content of the clinical definition with their own impressionistic views.[21]

("Evaluators are discouraged from utilizing criminal behavior to ascertain the presence or absence of deficits in adaptive functioning."); AAIDD, *User's Guide: Intellectual Disability: Definition, Classification, and Systems of Supports* 18 (2012) ("Distinguish between adaptive behavior and problem behavior(s). They are independent constructs and not opposite poles of a continuum. Information regarding problem behavior does not inform the clinician regarding the person's adaptive behavior."); *id.* at 20 ("Do not use past criminal behavior or verbal behavior to infer level of adaptive behavior. The diagnosis of intellectual disability is based on meeting three criteria: significant limitations in intellectual functioning; significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills; and age of onset prior to age 18. The diagnosis of ID is not based on the person's 'street smarts,' behavior in jail or prison, or 'criminal adaptive functioning.'"); Stephen Greenspan, *The Briseno Factors*, in *The Death Penalty and Intellectual Disability* 219, 228 (Edward A. Polloway ed., 2015).

This Court has noted the tension between relying on the facts of the crime and the clinical reality that adaptive strengths coexist with weaknesses. *See Brumfield v. Cain*, 135 S. Ct. 2269, 2281 (2015).

[21] Gilbert S. Macvaugh III & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 155 (2009) ("Such idiosyncratic methods and intuitive observations have no normative comparisons, have not been scientifically tested, have no known reliability or validity, and reflect unscientific, unsystematic and potentially confirmatory sampling bias. Whatever their anecdotal appeal, such methods lack scientific rigor and are not appropriate expressions of clinical judgment."). *See* American Psychological Association, *Specialty Guidelines for Forensic Psychology*, 68 Am. Psychologist 7, 15 (2013) ("Forensic practitioners use assessment procedures in

Diagnoses lack validity when basic scientific principles are ignored.

III. Adhering to Scientific Principles of Adaptive Behavior Deficits Is Just as Essential as Compliance with the Intellectual Functioning Requirement.

In *Hall* this Court concluded that "Freddie Lee Hall may or may not be intellectually disabled, but the law requires that he have the opportunity to present evidence of his intellectual disability, including deficits in adaptive functioning over his lifetime." 134 S. Ct. at 2001. In that case, Florida's refusal to acknowledge the scientific reality of standard measurement error in IQ testing violated the Eighth Amendment, in large part, because "[s]ociety relies upon medical and professional expertise to define and explain how to diagnose the mental condition at issue." *Id.* at 1993.

Texas's insistence on ignoring the clinical and diagnostic standards regarding deficits in adaptive behavior is an even more radical departure from

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the manner and for the purposes that are appropriate in light of the research on or evidence of their usefulness and proper application."); American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, 57 Am. Psychologist 1060, 1064 (2002) ("Psychologists' work is based upon established scientific and professional knowledge of the discipline.") (Standard 2.04); s*ee also* Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 15 (2d ed. 2014) ("Clinical judgment is *not* . . . a vehicle for stereotypes or prejudices . . . .") (emphasis in original).

accepted scientific principles than was Florida's rule in *Hall*.[22]

Every capital defendant who claims to have intellectual disability should have the relevant evidence evaluated according to scientific standards. The Texas "factors" bear little resemblance to the professional definition's clear focus on deficits in adaptive behavior. They are not consistent with accepted diagnostic standards and practices. Any failure to adhere to the definition inevitably produces results that cannot be reconciled with the clinical meaning of intellectual disability.

Texas's departure from the accepted definition limits the protection of *Atkins* to only a subset of the individuals who actually have intellectual disability.

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[22] The lower court in *Hall* had departed from accepted clinical standards by imposing a numerical ceiling on IQ scores that was inconsistent with the statistical properties of the psychometric instruments used to measure IQ. *Hall*, 134 S. Ct. at 2000 ("By failing to take into account the SEM and setting a strict cutoff at 70, Florida goes against the unanimous professional consensus. Neither Florida nor its *amici* point to a single medical professional who supports this cutoff.") (internal quotation omitted). In Texas, by contrast, the state court has actually altered the meaning of the second prong of the definition.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to grant the petition for a writ of certiorari.

Respectfully submitted,

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