No. 15-797

IN THE
Supreme Court of the United States

BOBBY JAMES MOORE,
Petitioner,

v.

TEXAS,
Respondent.

ON WRIT OF CERTIORARI TO THE
COURT OF CRIMINAL APPEALS OF TEXAS

BRIEF OF *AMICI CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, NATIONAL ASSOCIATION OF SOCIAL WORKERS, AND NATIONAL ASSOCIATION OF SOCIAL WORKERS TEXAS CHAPTER IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

OTHER AUTHORITIES

INTEREST OF *AMICI*[1]

The American Psychological Association is a scientific and educational organization dedicated to increasing and disseminating psychological knowledge; it is the world's largest professional association of psychologists, with 120,000 members. Among the Association's major purposes are to increase and disseminate knowledge regarding human behavior, and to foster the application of psychological learning to important human concerns. The Association's Division of Intellectual and Developmental Disabilities/Autism Spectrum Disorders endeavors to advance the treatment of intellectual and developmental disabilities, based on scientific inquiry and high standards of practice. The Association's Division of Neuropsychology, in collaboration with other national neuropsychology organizations (National Academy of Neuropsychology, American Board of Clinical Neuropsychology and their Academy, and the American Board of Clinical Neuropsychology) works to advance the understanding and treatment of brain conditions affecting intellectual development and disability, based on scientific inquiry and high standards of practice.

The American Psychiatric Association, with more than 36,000 members, is the Nation's leading organization of physicians who specialize in psychiatry. Its member physicians work to ensure humane care and

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[1] This brief was written by counsel for amici, as listed on the cover, and not by counsel for any party. No outside contributions were made to the preparation or submission of this brief. Both parties have given written consent to the filing of this brief.

effective treatment for all persons with mental disorders, including intellectual disability. Association members engage in psychiatric treatment, research, and forensic activities, and many of them regularly perform roles in the criminal justice system. The American Psychiatric Association and its members have substantial knowledge and experience relevant to the issues in this case. In 2013, the American Psychiatric Association published the Fifth Edition of its Diagnostic and Statistical Manual of Mental Disorders ("DSM-5"). DSM-5 provides a revised definition for intellectual disability (intellectual developmental disorder) based on expert consensus, review of the scientific literature, and contributions from other professional societies.

American Academy of Psychiatry and the Law, with approximately 2,000 psychiatrist members dedicated to excellence in practice, teaching, and research in forensic psychiatry, has participated as an *amicus curiae* in, among other cases, *Hall v. Florida*, 134 S. Ct. 1986, 1994 (2014); *Brown v. Plata*, 563 U.S. 493 (2011); *Indiana v. Edwards*, 554 U.S. 164 (2008); *Clark v. Arizona*, 548 U.S. 735 (2006); and *Penry v. Johnson*, 532 U.S. 782 (2001).

The National Association of Social Workers ("NASW") is a professional membership organization with 130,000 social workers in chapters in every State, the District of Columbia, and internationally. The NASW Texas Chapter has approximately 5,600 members. Since 1955, NASW has worked to develop high standards of social work practice while unifying the social work profession. NASW promulgates professional policies, conducts research, publishes

professional studies and books, provides continuing education and enforces the *NASW Code of Ethics*.

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The issue at the heart of this case—the identification of individuals with intellectual disability—has been the subject of significant research by psychologists, psychiatrists, and other mental health professionals. Amici submit this brief to present relevant scientific knowledge that can provide context for the Court's review of whether Texas's system for identifying individuals with intellectual disability in capital cases violates the Eighth Amendment and this Court's decisions in *Atkins v. Virginia*, 536 U.S. 304 (2002) and *Hall v. Florida*, 134 S. Ct. 1986 (2014).

SUMMARY OF ARGUMENT

In *Atkins v. Virginia*, this Court held that the Eighth Amendment prohibits the execution of individuals with intellectual disability. 536 U.S. 304, 321 (2002). This Court's decision was grounded in the recognition that individuals with intellectual disability (then referred to as mental retardation) have impairments of intellectual and adaptive functioning that make them less morally culpable and place them at a heightened risk of wrongful execution. *Id.* at 318, 320–21. *Atkins* relied on the clinical definitions promulgated by mental health professionals to identify intellectual disability. *Id.* at 308 n.3, 318.

Hall v. Florida, decided two years ago, reiterated the constitutional prohibition on the execution of individuals with intellectual disability. 134 S. Ct. 1986, 1990 (2014). In doing so, this Court held that Florida's

rule that an individual who scores above 70 on an IQ test—including a score within the margin for measurement error—is barred from presenting other evidence of intellectual disability "create[d] an unacceptable risk that persons with intellectual disability will be executed, and this is unconstitutional." *Id.* Florida's rule was unconstitutional because its definition of intellectual disability was inconsistent with the clinical standards of diagnosis adopted by the mental health professions. *See id.* at 1993 ("In determining who qualifies as intellectually disabled, it is proper to consult the medical community's opinions.").

In assessing whether an individual meets the clinical definition of intellectual disability, there is a unanimous consensus among the mental health professions that accurate diagnosis requires clinical judgment based on a comprehensive assessment of three criteria: general intellectual functioning, adaptive functioning, and onset during the developmental period. A state's failure to follow the appropriate diagnostic approach violates applicable professional standards and creates an unacceptable and significant risk that individuals with intellectual disability may be executed in violation of the Eighth Amendment and this Court's decisions in *Atkins* and *Hall*.

The Texas Court of Criminal Appeals in *Ex Parte Moore* failed to apply the consensus criteria for diagnosing intellectual disability. *Ex Parte Moore*, 470 S.W.3d 481, 486-87 (Tex. Crim. App. 2015), *cert. granted*

in part, 136 S. Ct. 2407 (2016).[2] Texas fails to abide by the clinical definition of intellectual disability in three ways.

First, the Texas Court of Criminal Appeals fails to follow current clinical standards by relying on an outdated 1992 diagnostic manual rather than applicable contemporary manuals. App. at 5a. As the scientific and medical knowledge in the area of mental health have evolved and advanced, so have the diagnostic standards adopted and utilized by the mental health professions. Texas's refusal to recognize these diagnostic advances is incompatible with this Court's Eighth Amendment jurisprudence.

Second, the Texas Court of Criminal Appeals fails to follow the appropriate diagnostic standards regarding IQ test scores that were at issue in this Court's decision in *Hall*. The court in *Ex Parte Moore* recognized that Moore had an IQ score between 69 and 79 after applying the appropriate standard error of measurement. App. at 74a–75a. The lower range of this score, approximately two standard deviations below the mean, is sufficient—after the application of clinical judgment—to diagnose significant limitations in intellectual functioning. Yet the *Ex Parte Moore* court instead found that this score represented intellectual functioning "above the intellectually disabled range." *Id.* at 75a. This conclusion has no clinical basis and is in conflict with consensus diagnostic practices.

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[2] The decision of the Court of Criminal Appeals is reprinted in Petitioner's Appendix to the Petition for Certiorari ("App.") at App. 1a–126a.

Third, Texas continues to rely on additional, non-clinical "factors" to determine whether an individual is intellectually disabled for purposes of the Eighth Amendment beyond the diagnostic criteria used by mental health professionals. These factors, first articulated in *Ex parte Briseño*, 135 S.W.3d 1, 8–9 (Tex. Crim. App. 2004), are unsupported by any scientific or medical evidence and inconsistent with the professional standards used by mental health professionals to diagnose intellectual disability. Instead, the so-called *Briseño* factors are an invention of the Texas Court of Criminal Appeals based on (1) unwarranted lay stereotypes of persons with intellectual disability; (2) the mistaken notion that the presence of some adaptive strengths signals a lack of intellectual disability; (3) an unwarranted emphasis on atypical behavior; and (4) a mistaken understanding of the relationship between intellectual disability and mental disorders. Simply put, the presence or absence of the various factors identified in *Briseño* is not a reliable indication of intellectual disability.

Each of these divergences from the professional consensus of the mental health professions on the diagnosis of intellectual disability creates an extraordinary risk that persons with intellectual disability will be executed in violation of the Eighth Amendment.

ARGUMENT

I. There Is Unanimous Professional Consensus on the Criteria Applied to Diagnose Intellectual Disability.

As this Court has recognized, there is a consensus among mental health professionals on the criteria to diagnose intellectual disability. *Hall*, 134 S. Ct. at 1993–94; *Atkins*, 536 U.S. at 308 n.3. The accepted clinical definitions of intellectual disability include three criteria: (1) significant limitations in general intellectual functioning; (2) significant limitations in adaptive functioning; and (3) onset during the developmental period. *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 33 (5th ed. 2013) ("DSM-5"); Am. Ass'n on Intellectual & Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Support* 27 (11th ed. 2010) ("AAIDD Manual").[3] The Court has cited and relied on the definitions of intellectual disability from the American Psychiatric Association and the American Association on Intellectual and Development Disabilities ("AAIDD") in its decisions. *See Hall*, 134 S. Ct. at 1990 (citing the DSM-5); *Atkins*, 536 U.S. at 308 n.3 (citing earlier versions of the AAIDD Manual and the DSM).

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[3] The AAIDD Manual and DSM-5 definitions of intellectual disability differ in some particulars not relevant for the purposes of this brief or the question presented to the Court in this case.

A. The existence of concurrent deficits in intellectual and adaptive functioning is central to the diagnosis of intellectual disability.

In order to accurately diagnose intellectual disability, a mental health professional must make a comprehensive assessment of a person's intellectual and adaptive functioning.[4] A comprehensive assessment must be "based on multiple data points" that "include giving equal consideration to significant limitations in adaptive behavior and intellectual functioning." AAIDD Manual at 28. Adaptive skills—such as abstract thinking, social judgment, regulating emotion, and resisting manipulation by others—are crucial to an individual's ability to live independently and function within the boundaries of social norms. *See* DSM-5 at 33–34; AAIDD Manual at 44-45. And the assessment of adaptive functioning is necessary to arrive at a valid diagnosis of intellectual disability. DSM-5 at 37-38; AAIDD Manual at 44-46.

The criteria to diagnose intellectual disability are not evaluated separately, in disjunctive inquiries, but are rather considered together during a clinical evaluation by a mental health professional. *See* DSM-5 at 37 ("The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions."); AAIDD Manual at 29 ("[c]linical judgment is essential"). Contrary to the Texas Court of Criminal Appeal's decision in *Ex Parte*

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[4] The third criterion, onset during the developmental period, requires that the deficits be present before the person reaches adulthood. DSM-5 at 33; AAIDD Manual at 6.

Moore, the requirement that the deficits in adaptive behavior must be "related" to the impairments in intellectual functioning does not alter the normal assessment. *See* App. at 6a & n.4 (citing DSM-IV at 46). The current diagnostic criteria require a connection between the deficits in intellectual functioning and adaptive functioning, but that connection need only exclude the obvious limits to adaptive functioning imposed by other ailments. The most obvious of those include physical disabilities that impair sensory abilities (*e.g.*, blindness or deafness). Whether a deficit in adaptive functioning is "related" to intellectual impairments is a clinical judgment and cannot be reduced to a layperson's "just so" stories. The notion that a court could determine that deficits in adaptive and intellectual functioning were *unrelated* based on the non-clinical, so-called *Briseño* factors is unsupported by scientific or medical research.

In *Hall*, this Court addressed in depth the first element of intellectual disability: significantly sub-average intellectual functioning. *Hall*, 134 S. Ct. at 1994–96. In particular, *Hall* emphasized that an IQ score derived from a test cannot alone be considered "final and conclusive evidence of a defendant's intellectual capacity" and that such scores must be interpreted properly, which requires, *inter alia*, appreciation of a score's standard error of measurement or "SEM." *Id.* at 1995.

B. Assessment of deficits in adaptive functioning is necessary to diagnose intellectual disability.

Adaptive functioning, the second element of intellectual disability, is the "collection of conceptual,

social, and practical skills that have been learned and are performed by people in their everyday lives." AAIDD Manual at 45. "Deficits in adaptive functioning . . . refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background." DSM-5 at 37. Adaptive functioning involves adaptive reasoning in three domains—conceptual, social, and practical—which are grounded in substantial empirical studies. AAIDD Manual at 44; *see also* Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114 (2009) (hereinafter "*Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*").[5] Representative skills in the three domains include:

- *Conceptual skills* that include language, reading and writing, and mathematical reasoning;
- *Social skills* that include interpersonal skills, empathy, and social judgment and problem solving; and
- *Practical skills* that include personal care, occupational skills, schedules, and task organization.

See AAIDD Manual at 44; DSM-5 at 37.

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[5] The preferred clinical term is now "intellectual disability," rather than "mental retardation," which was the term used by the *Atkins* court. *See* AAIDD Manual at 3.

Adaptive functioning is assessed using clinical evaluation in combination with systematic review of existing records and pertinent standardized tests. AAIDD Manual at 47; DSM-5 at 37. Evaluating adaptive functioning requires collecting records and information regarding an individual's functioning over time and in disparate settings.[6] As this Court has acknowledged, the mental health community accepts, as potentially "probative of intellectual disability," a variety of "substantial and weighty evidence of intellectual disability as measured and made manifest by the defendant's failure or inability to adapt to his social and cultural environment, including medical histories, behavioral records, school tests and reports, and testimony regarding past behavior and family circumstances." *Hall*, 134 S. Ct. at 1994. Mental health professionals have developed standardized measures to evaluate adaptive functioning. *See generally* J. Gregory Olley, *Adaptive Behavior Instruments*, in *The Death Penalty and Intellectual Disability* 187–98 (Edward A. Polloway ed., 2015) (hereinafter "*Adaptive Behavior Instruments*"); *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases* at 117–18.

The clinical assessment of deficits in adaptive functioning uses standardized measures. AAIDD Manual at 47; DSM-5 at 37. Contrary to the opinion of

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[6] *See Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases* at 119 ("The ideal respondents are individuals who have the most knowledge of the individual's everyday functioning across settings . . . .").

the Texas Court of Criminal Appeals, the clinical diagnosis of deficits in adaptive functioning is not "exceedingly subjective." *Ex parte Briseño*, 135 S.W.3d at 8. Indeed, the development and refinement of standardized instruments to measure adaptive behavior has greatly improved the diagnosis of intellectual disability. *See* Adaptive Behavior Instruments at 187–88. There are currently three contemporary scales used to diagnose limitations in adaptive behavior along with a forthcoming instrument.[7] Each of these instruments meets "contemporary standards for standardization, reliability, and validity." *Id.* at 189.[8] It is simply incorrect to assert—especially without reference to authority—that the assessment of adaptive functioning

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[7] The three contemporary scales are the Scales of Independent Behavior-Revised (Bruininks, Woodcock, Weatherman, & Hill, 1996); the Adaptive Behavior Assessment System (Harrison & Oakland, 2015); and the Vineland Adaptive Behavior Scales (Sparrow, Cicchetti, & Balla, 2008). The forthcoming instrument is the Diagnostic Adaptive Behavior Scale (Tassé et al., in press).

[8] Assessment of adaptive behaviors requires the use of current testing instruments. Am. Educ. Research Ass'n et al., *Standards for Educational and Psychological Testing* 93 (2014) (hereinafter "*Standards for Educational and Psychological Testing*") ("If an older version of a test is used when a newer version has been published or made available, test users are responsible for providing evidence that the older version is as appropriate as the new version for that particular test use.").

is subjective when done according to the accepted clinical standards.

A person must have a significant limitation in adaptive behavior in one of the three skill domains. AAIDD Manual at 47 (defining "significant" as two standard deviations below the population average); DSM-5 at 37–38 (noting that one or more domains of adaptive functioning must be "sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, at work, at home, or in the community").

Importantly, mental health professionals agree that intellectual disability can and should be diagnosed where there are sufficient *deficits* in adaptive functioning. That remains true even if the individual has relative strengths in other areas. The presence of relative strengths in some spheres of behavior is *not* evidence that a person does *not* have intellectual disability. AAIDD Manual at 45 ("adaptive skill limitations often coexist with strengths"); *see also 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 the 2002 AAMR Manual)).

II. The Use of Outdated or Non-Clinical Criteria to Diagnose Intellectual Disability Violates the Professional Consensus and Clinical Norms of Mental Health Professionals.

In *Hall*, the Court faced Florida's "disregard [of] established medical practice" with regard to the intellectual functioning element of intellectual disability. *Hall*, 134 S. Ct. at 1995. Here, Petitioner presents the Court with a state that ignores established professional consensus regarding (1) the use of current diagnostic criteria; (2) the failure to apply the appropriate clinical standards when assessing deficits in intellectual functioning; and (3) the failure to apply the appropriate clinical standards when assessing deficits in adaptive functioning, including relying on non-clinical factors created out of whole cloth by the Texas Court of Criminal Appeals.

A. Texas disregards the current diagnostic consensus of mental health professionals when evaluating *Atkins* claims.

The criteria used to diagnose intellectual disability have evolved over time. AAIDD Manual at xiv; DSM-5 at 5. Changes from previous diagnostic manuals are grounded in the advancement of scientific and medical knowledge. DSM-5 at 6–7; AAIDD Manual at xiv–xvi. The refinement of the diagnostic criteria of intellectual disability is evidence of the scientific method at work. As mental health professionals learn more about intellectual disability, the ability of clinicians to diagnose intellectual ability is improved. Further, the instruments necessary for the objective diagnosis of intellectual disability also continue to improve. *See*

Kevin S. McGrew, *Intellectual Functioning*, in *The Death Penalty and Intellectual Disability* 85, 87-89 (Edward A. Polloway ed., 2015); *Adaptive Behavior Instruments* at 187–90.

Notwithstanding the advances in understanding and diagnosing intellectual disability, Texas continues to rely on an outdated diagnostic manual from 1992. *See* App. at 6a. This reliance is not justified by scientific or medical practice and risks the misdiagnosis of persons with intellectual disability.

B. Texas fails to properly assess deficits in intellectual deficiencies.

Hall recognized that "[a]n IQ score is an approximation, not a final and infallible assessment of intellectual functioning." 134 S. Ct. at 2000. Thus, the proper assessment of intellectual functioning requires clinical judgment beyond a simplistic determination that IQ scores above a certain measure conclusively determine that a person does not have intellectual disability. *Id.* ("It is not sound to view a single factor as dispositive of a conjunctive and interrelated assessment." (citing DSM-5 at 37)).

The court in *Ex Parte Moore* excluded a number of IQ test scores, relying on two of the higher scores to conclude that Moore does not have sufficient deficits in intellectual functioning to be diagnosed with intellectual disability. App. at 69a–75a. Setting aside the court's decision to exclude five of the seven IQ test scores,[9] the

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[9] *Amici* do not address whether the Texas Court of Criminal Appeals erred in disregarding any particular test. Instead,

Texas's court's failure to recognize that one of the two remaining IQ test scores was within the range of deficits necessary to diagnose intellectual disability—given SEM—is inconsistent with and contrary to the consensus diagnostic practices. *See* AAIDD Manual at 35–36 (describing appropriate use of SEM). A score of 74—as Moore received—on an accepted IQ test is sufficient, with further clinical judgment, to justify a diagnosis of intellectual disability.

C. Texas uses factors to identify intellectual disability that lack any basis in science or medicine and are inconsistent with professional, clinical diagnostic practices.

Texas's reliance on the so-called *Briseño* factors to diagnose intellectual disability is incompatible with the diagnostic consensus of mental health professionals. Instead of providing reliable indicia of deficits in adaptive functioning, *see supra* I.B, the factors Texas allows factfinders to use to determine eligibility for relief under *Atkins* distort the assessment of adaptive functioning by (1) relying on stereotypes of intellectual

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Amici emphasize that while there are well-established clinical reasons to disregard a particular IQ score from an assessment of intellectual disability, such a decision must be grounded in clinical judgment. *See Standards for Educational and Psychological Testing* 7 ("[E]valuating acceptability [of a test] depends on [factors including] professional judgment that is based on a knowledge of behavioral science, psychometrics, and the relevant standards in the professional field to which the test applies"); DSM-5 at 37 ("Clinical training and judgment are required to interpret test results and assess intellectual performance.").

disability; (2) focusing on strengths rather than deficits; (3) emphasizing atypical behavior; and (4) excluding a diagnosis of intellectual disability when other mental disorders are present.

After this Court's decision in *Atkins*, the Texas Court of Criminal Appeals adopted non-clinical factors to be used to determine whether individuals were intellectually disabled. *Ex parte Briseño*, 135 S.W.3d at 8–9. The court in *Briseño* cited no mental health or medical authority as the basis for these factors, instead alluding to a fictional character in John Steinbeck's 1937 novel *Of Mice and Men* as the basis for its reasoning about intellectual disability diagnosis. *Id.*

The *Briseño* factors have four substantial flaws that make them unsuitable to diagnose intellectual disability.

Lay stereotypes of intellectual disability. The factors indulge lay opinions and stereotypes about those who are intellectually disabled. The *Briseño* factors are more consistent with stereotypes of the intellectually disabled rather than clinical standards used by mental health professionals to diagnose intellectual disability. *See* "Choice and Control" (studying how persons with intellectual disability exercised forms of autonomy with the assistance of social workers). Texas's reliance on stereotypes rather than the accepted clinical criteria for diagnosing intellectual disability risks misdiagnosing individuals due to mistaken assumptions about persons with intellectual disability. *See* David L. Hamilton & A. Neville Uhles, *Stereotypes*, 7 Encyclopedia of Psychol. 466, 466–70 (2000) (identifying the consequences of

stereotyping as increased confirmation bias, in-group discrimination, and self-fulfilling prophecy).

Inappropriate emphasis on individual strengths or competences. Persons who have intellectual disability are not typically incompetent across all domains. "Individuals with an [intellectual disability] typically demonstrate both strengths and limitations in adaptive behavior." AAIDD Manual at 47. Yet the *Briseño* decision assumes that any demonstration of relative competence disqualifies one from having intellectual disability. This is not correct. Intellectually disabled persons can exhibit relative strengths. *See*, *e.g.*, Kathryn K. Yamamoto, *et al.*, *Inclusive Postsecondary Education: Reimagining the Transition Trajectories of Vocational Rehabilitation Clients with Intellectual Disabilities*, 40 J. Vocational Rehab. 59, 60, 64 (2014) (identifying post-secondary opportunities for persons with intellectual disability); Joke J.H. Ellenkamp, *Work Environment-Related Factors in Obtaining and Maintaining Work in a Competitive Employment Setting for Employees with Intellectual Disabilities: A Systematic Review*, 26 J. Occup. Rehab. 56, 57 (2016) (citing estimates that between 9 and 40 percent of persons with intellectual disability have some form of paid employment). Thus, the reality of mixed competencies can conflict with stereotypes of persons with intellectual disability that portray these individuals as comprehensively deficient. One scholar has explained the very risk created by *Briseño*:

> These strengths may confound a layperson or a professional with limited clinical experience with individuals who have mild

> [intellectual disability]. These laypersons may erroneously interpret these pockets of strengths and skills as inconsistent with [intellectual disability] because of their misconceptions regarding what someone with [intellectual disability] can or cannot do.

Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases at 121.

Focus on the atypical. The diagnosis of deficits in adaptive functioning requires a focus "on the individual's typical performance and not their best or assumed ability or maximum performance." AAIDD Manual at 47 (noting the contrast between adaptive functioning—which focuses on the typical—and intellectual functioning with its assessment of maximum performance); *see also* DSM-5 at 33.

Exclusion of personality disorders. *Ex parte Briseño* appears to treat intellectual disability as inconsistent with personality disorders. 135 S.W.3d at 8–9. But, to the contrary, persons with intellectual disability are three to four times more likely to have co-occurring mental disorders—with personality disorders being one type of many such disorders—than the general population. DSM-5 at 40. The existence of a personality disorder or other mental health issue is emphatically not evidence that a person does not also have intellectual disability. *See* Jannelien Weiland, *et al.*, *The Prevalence of Personality Disorders in Psychiatric Outpatients with Borderline Intellectual Functioning: Comparison with Outpatients from Regular Mental Health Care and Outpatients with Mild*

Intellectual Disabilities, 69 Nordic J. Psychiatry 599, 602 (2015) ("[T]here is growing evidence that low IQ is associated with increased risk of and severity of mental disorders, including [personality disorders]…."); National Ass'n for the Dually Diagnosed, *Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability (DM-ID)* 248–49 (Robert Fletcher et al. eds., 2007) (2007) (hereinafter "*Diagnostic Manual – Intellectual Disability*"); *see also Lambert v. State*, 126 P.3d 646, 655 (Okla. Crim. App. 2005) (once adaptive functioning deficits were conceded, evidence that mental illness may have played a causal role was irrelevant and inadmissible). Clinical practice does not require this creation of a "false dichotomy" between mental illness and intellectual disability, which mental health professionals recognize may coexist or may even be interrelated. *See* DSM-5 at 38–40 (stating that the course of intellectual disability "may be influenced by underlying medical or genetic conditions and co-occurring conditions" and that "[c]o-occurring mental, neurodevelopmental, medical, and physical conditions are frequent in intellectual disability").

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Not one of the Briseño factors is a sufficient or necessary element of the clinical definition of intellectual disability. The seven factors invented by the Texas Court of Criminal Appeals cannot reliably or accurately be used to identify intellectual disability. The flaws of

each factor, *Ex parte Briseño*, 135 S.W.3d at 8–9, are described below:

> *1. Did those who knew the person best during the developmental stage—his family, friends, teachers, employers, authorities—think he was mentally retarded at that time, and, if so, act in accordance with that determination?*

While mental health professionals interview individuals who knew the subject when assessing adaptive functioning, a layperson's *recognition* of intellectual disability is neither sufficient nor necessary. Indeed, families may avoid making statements that would associate an individual or the individual's family with the stigma associated with the label of intellectual disability. Family members or community members may lack objectivity and will likely possess varying levels of awareness regarding intellectual disability and its indicators. The absence of a layperson's opinion that an individual has intellectual disability is *not* reliable evidence that the person does not have intellectual disability. This is why clinical interviews of family members ask about the individual's typical behavior but do not ask family members to make a diagnosis. To do otherwise is to substitute a layperson's untrained opinion for that of a mental health professional.

> *2. Has the person formulated plans and carried them through or is his conduct impulsive?*

Impulsivity is a feature of personality and not intellectual disability. F. Gerard Moeller *et al.*, *Psychiatric Aspects of Impulsivity*, 158 Am. J. Psychiatry 1783 (Nov. 2001) (hereinafter "*Psychiatric*

Aspects of Impulsivity"). The fact that some persons with intellectual disability behave impulsively does not make it evidence of intellectual disability. AAIDD Manual at 47. Nor is the ability to formulate plans and carry them out the opposite of impulsivity. *See Psychiatric Aspects of Impulsivity* at 1784. Even persons who are impulsive may formulate and carry out plans. Impulsivity is not part of the clinical definition of intellectual disability. AAIDD Manual at 27–29; DSM-5 at 33. Nor would a single example of formulating and carrying out a plan exclude a diagnosis of intellectual disability. While difficulty planning is relevant to the diagnosis of intellectual disability, *see* DSM-5 at 33, it is only one of multiple potential indicators.

3. Does his conduct show leadership or does it show that he is led around by others?

While substantial gullibility or naïveté can be evidence of deficits in social adaptive behavior, AAIDD Manual at 44; DSM-5 at 34, 38, examples of leadership do not demonstrate that a person does not have intellectual disability. As discussed above, adaptive strengths or instances in which an individual shows leadership do not negate the adaptive deficits which indicate intellectual disability.

4. Is his conduct in response to external stimuli rational and appropriate, regardless of whether it is socially acceptable?

The concepts of "rational" and "appropriate" are situation-specific. Contexts and typical behavior matter a great deal, and anecdotal evidence of "rational" or "appropriate" behavior in any given context cannot

demonstrate that one does or does not have intellectual disability. Further, and perhaps more central to the problem with this factor is that placing emphasis on "rationality" evidences a common confusion between mental illness and intellectual disability. Irrational thinking is characteristic of mental illness. *Diagnostic Manual – Intellectual Disability*. People with intellectual disability experience significant difficulties with learning and judgment, but there is nothing in any definition of intellectual disability to indicate that irrational thinking is diagnostic.

5. *Does he respond coherently, rationally, and on point to oral or written questions or do his responses wander from subject to subject?*

Expressive and receptive language and communication skills are certainly relevant to the diagnosis of intellectual disability. AAIDD Manual at 44 (noting that language as well as reading and writing are conceptual skills); DSM-5 at 37 (same). However, lay interpretations of isolated or limited communications are insufficient to diagnose a deficiency in an individual's adaptive functioning outside of a comprehensive clinical assessment. J. Gregory Olley, *The Death Penalty, the Courts, and Intellectual Disabilities, in The Handbook of High-Risk Challenging Behavior: Assessment and Intervention* 229, 236–37 (J.K. Luiselli ed., 2011) (hereinafter "*The Death Penalty, the Courts, and Intellectual Disabilities*"). And, as noted above, irrationality is not an element used to diagnose intellectual disability. *See supra* at 22. Similarly, lack of coherence is a symptom that is more associated with mental disorders, like psychosis, rather than a symptom

of intellectual disability. *See* Paul White et al., *Prevalence of Intellectual Disability and Comorbid Mental Illness in an Australian Community Sample*, 39 Austral. & N.Z. J. Psychiatry 395–400 (May 2006).

This factor is particularly irrelevant for persons who have mild intellectual disability. Persons with mild intellectual disability may marry, have jobs, and participate meaningfully in society with adequate support. AAIDD Manual at 151–66; DSM-5 at 34–36. Laypersons, including courts, may misunderstand mild intellectual disability by assuming that individuals with intellectual disability will be easy to identify based on physical appearance or speech. *See The Death Penalty, the Courts, and Intellectual Disabilities* at 231. Reliance on stereotypes ignores the reality that "mild ID typically presents no obvious physical signs and . . . such individuals have many areas of competence to accompany areas of impairment." *Id.* Texas's non-clinical standard, holding that any person who can communicate rationally and coherently does not have intellectual disability, ignores the reality that individuals with intellectual disability have varied abilities and experiences. It effectively eliminates a significant portion of persons who have intellectual disability.

6. Can the person hide facts or lie effectively in his own or others' interests?

The ability to deceive has no relevance to the accepted clinical criteria for diagnosing intellectual disability. Indeed, there is little research on whether ability to deceive has a relationship to intellectual disability. However, the available literature does

suggest that persons with intellectual disability are able "to act deceptively in order to manipulate the behavior of others." Nurit Yirmiya *et al.*, *The Ability to Manipulate Behavior and to Understand Manipulation of Beliefs: A Comparison of Individuals with Autism, Mental Retardation, and Normal Development*, 32 Developmental Psychol. 62, 66 (1996). Since lying is a nearly universal behavior beginning in early childhood, *id.* at 62, this factor could exclude any person from being diagnosed with intellectual disability. Furthermore, it would be difficult to effectively evaluate this factor in a clinical setting because there is no clinical standard for assessing the ability to deceive.

7. *Putting aside any heinousness or gruesomeness surrounding the capital offense, did the commission of that offense require forethought, planning, and complex execution of purpose?*

There is no standard for what constitutes sufficient evidence of planning to demonstrate a lack of intellectual disability. Intellectual disability is not diagnosed by focusing on abilities or strengths, but instead by identifying deficits in adaptive functioning. The focus on the crime—one event—may come at the expense of other, more typical life events that provide a more accurate assessment of an individual's adaptive functioning. *See* Am. Bar Ass'n, *Evaluating Fairness and Accuracy in State Death Penalty Systems: The Texas Capital Punishment Assessment Report* 396 (Sept. 2013). It is a mistake for courts to accept one example of competent functioning when the assessment of adaptive deficits relates to an individual's deficits and weaknesses, not an individual's strengths. *See The*

Death Penalty, the Courts, and Intellectual Disabilities at 236.

CONCLUSION

There is a consensus among the mental health professions about how properly to diagnose persons with intellectual disability. Texas's approach to intellectual disability is inconsistent with this consensus. The mental health professions rely on contemporary diagnostic criteria that use the most accurate and reliable standards and instruments to diagnose intellectual disability. Consistent with this Court's decision in *Hall*, mental health professionals interpret IQ scores using appropriate clinical judgment, including the acceptance of the standard error of measurement. Finally, the so-called *Briseño* factors are incompatible with the consensus among the mental health professions and, when used, provide inaccurate and unreliable diagnoses of intellectual disability. The use of antiquated diagnostic criteria, refusal to interpret IQ scores using clinical standards, and the inclusion of non-clinical factors to diagnose intellectual disability all create significant risks that individuals with intellectual disability will be executed in violation of the Eighth Amendment. Instead, the appropriate method of diagnosis in every case is a comprehensive assessment of the individual's adaptive and general intellectual functioning using the mental health professions' clinical standards.

For the foregoing reasons, the diagnosis of intellectual disability in capital cases should be based on the diagnostic consensus of mental health professionals, which requires the comprehensive assessment of

intellectual and adaptive functioning using contemporary standards.

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