

IN THE COURT OF CRIMINAL APPEALS OF TEXAS

No. WR-13,374-05

EX PARTE BOBBY JAMES MOORE, Applicant.

ON REMAND FROM THE UNITED STATES SUPREME COURT

APPLICATION FOR WRIT OF HABEAS CORPUS IN
CAUSE NO. 314483-C IN THE 185TH JUDICIAL DISTRICT COURT
HARRIS COUNTY

**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
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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 Disorder 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.

¹ The fee for preparing this brief will be paid by the American Psychological Association. See Tex. R. App. P. 11(c). This brief was written by counsel for *amici*, as listed on the cover, and not by counsel for any party. No outside contributions from anyone other than *amici* and their counsel were made to the preparation or submission of this brief.

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 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.

The American Academy of Psychiatry and the Law ("AAPL"), with approximately 2000 psychiatrist members, is dedicated to excellence in practice, teaching, and research in forensic psychiatry. AAPL has participated as an *amicus curiae* in numerous cases presenting issues of importance to the psychiatric profession, including *Moore v. Texas*, 137 S. Ct. 1039 (2017), and *Hall v. Florida*, 134 S. Ct. 1986 (2014).

The National Association of Social Workers ("NASW") is a professional membership organization with 120,000 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*.

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 this Court’s consideration of a system for identifying individuals with intellectual disability in capital cases.

SUMMARY OF ARGUMENT

In *Atkins v. Virginia*, the United States Supreme Court held that the Eighth Amendment prohibits the execution of individuals with intellectual disability. 536 U.S. 304, 321 (2002). The 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. The *Atkins* court explained that, because of their impairments, persons with intellectual disability “have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.” *Id.* at 318. In reaching this conclusion, *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 by the United States Supreme Court three years ago, reiterated the constitutional prohibition on the execution of individuals with intellectual disability. 134 S. Ct. 1986, 1990 (2014). In doing so, the Supreme 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. The Court emphasized that “it is proper to consult the medical community’s opinions”—including opinions about standard error measurements—when “determining who qualifies as intellectually disabled.” *Id.* at 1993.

The Supreme Court applied the holdings of *Atkins* and *Hall* in this very case, stating that “adjudications of intellectual disability should be ‘informed by the views of medical experts’” and noting that this “instruction cannot sensibly be read to give courts leave to diminish the force of the medical community’s consensus.” *Moore v. Texas*, 137 S. Ct. 1039, 1044 (2016) (quoting *Hall*, 134 S. Ct. at 2000). The Supreme Court found that “[b]y rejecting the habeas court’s application of medical guidance and clinging to the standard it laid out in *Briseño*, including the wholly nonclinical *Briseño* factors, [this Court] failed adequately to inform itself of the ‘medical community’s diagnostic framework’” for identifying intellectual disability. *Id.* at 1053 (quoting *Hall*, 134 S. Ct. at 2000). That diagnostic framework is explained herein.

In assessing whether an individual meets the clinical definition of intellectual disability, this Court should recognize the 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 in conceptual, social, and practical domains; and onset during the developmental period. Failure to follow a diagnostic approach guided by these principles would violate applicable professional standards and create an unacceptable and significant risk that individuals with intellectual disability may be executed in violation of the Eighth Amendment and the United States Supreme Court's decisions in *Atkins*, *Hall*, and *Moore*.

Any assessment of intellectual functioning must appreciate the nuances of the “relatedness” issue for a diagnosis of intellectual disability. Current criteria as expressed in the DSM-5 indicate that deficits in intellectual and adaptive functioning are related. Adaptive behavior is the manifestation of intelligence applied to everyday problems. The term “adaptive reasoning” is used in the DSM-5 to express this idea. In this sense, intelligence and adaptive behavior are intertwined in everyday life and are related. In crafting a test for intellectual disability, this Court should recognize the current medical consensus that intellectual disability must be diagnosed where there are sufficient deficits in adaptive functioning in conceptual, social, and practical domains, and when the deficits were onset during the developmental period. A proper test for evaluating intellectual disability should recognize the importance of (1) focusing on

demonstrated deficits and not over-emphasizing perceived strengths, because it is the deficits that result in adaptive dysfunction; (2) appreciating that standardized test scores for intellectual functioning are used to make the diagnosis regardless of whether there is a concurrently occurring mental disorder; and (3) assessing adaptive functioning in real-world settings and recognizing that the capacity to follow routines in a correctional setting may be misleading. Although evaluators should be free to consider all types of evidence when conducting a holistic weighing of all the data, such data must be contextualized, and evaluators should acknowledge the limitations of certain types of data when conducting their analyses. Moreover, this Court should recognize that individuals with intellectual disability have a range of mental abilities. As such, it is appropriate and common to identify the full range of these abilities—both strengths and deficits that meet the diagnostic criteria for intellectual disability. Regrettably, reliance on long-standing stereotypes rather than the accepted clinical criteria for diagnosing intellectual disability can result in misdiagnosing individuals due to mistaken assumptions about persons with intellectual disability.

ARGUMENT

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

As the United States Supreme Court has recognized, there is a consensus among mental health professionals on the criteria to diagnose intellectual disability. *Moore*, 137 S. Ct. at 1045; *Hall*, 134 S. Ct. at 1993–94; *Atkins*, 536 U.S. at 308 n.3. The currently 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.² 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”); see

² In crafting a test to determine intellectual disability, this Court should consider the current diagnostic consensus rather than outmoded or superseded methods. 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. Furthermore, 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); J. Gregory Olley, *Adaptive Behavior Instruments*, in *The Death Penalty and Intellectual Disability* 187–90 (Edward A. Polloway ed., 2015) (hereinafter “*Adaptive Behavior Instruments*”).

also *Moore*, 137 S. Ct. at 1045 (noting that these “three core elements” comprise the “the generally accepted, uncontroversial intellectual-disability diagnostic definition”).³ The Supreme 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 *Moore*, 137 S. Ct. at 1045, 1049-51 (citing the DSM-5 and the AAIDD Manual); *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).

A. The Existence of Concurrent Deficits in Intellectual and Adaptive Functioning is Key to the Diagnosis of Intellectual Disability.

The clinical consensus is that 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

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.

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.

reasoning 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; see also *Atkins*, 536 U.S. at 308 n.3, 318. 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.

1. In *Hall*, the United States Supreme 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. Because “[a]n IQ score is an approximation, not a final and infallible assessment of intellectual functioning,” *id.* at 2000, 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.*; see DSM-5 at 37.

This Court’s prior decision in *Ex Parte Moore* excluded a number of IQ test scores, relying on two of the higher scores to conclude that Mr. Moore does not have sufficient deficits in intellectual functioning to be diagnosed with intellectual

disability. 470 S.W.3d 481, 514-19 (Tex. Crim. App. 2015). Even if this Court were correct in excluding five of the seven IQ test scores,⁵ such exclusions would still leave one IQ test score of 74.

As this Court’s prior opinion recognized, that score of 74 was a valid result of an accepted IQ test. *Id.* at 519. Proper application of SEM leads to a confidence interval that is 5 IQ points above and below the obtained IQ score. Thus, given SEM, the IQ test score of 74 was within the range of deficits necessary to diagnose intellectual disability. Any conclusion to the contrary would be 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 Mr. Moore received—on an accepted IQ test is sufficient, with further clinical judgment, to show deficits in intellectual functioning and fulfill this requirement for the diagnosis of intellectual disability. *Cf. Moore*, 137 S. Ct. at 1049 (“Because the lower end of Moore’s score range falls at or below 70, the CCA had to move

⁵ *Amici* do not address whether this Court’s prior opinion erred in disregarding any particular test. Instead, *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* Am. Educ. Research Ass’n et al., *Standards for Educational and Psychological Testing* 7 (2014) (hereinafter “*Standards for Educational and Psychological Testing*”) (“[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.”).

on to consider Moore’s adaptive functioning. . . . [T]he presence of other sources of imprecision in administering the test to a particular individual cannot *narrow* the test-specific standard-error range.” (internal citations omitted)).

2. 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—that 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*”).⁶ Deficits in adaptive functioning are found where a person has a significant limitation in adaptive behavior in at least one of those three domains. Representative skills in the three domains encompass:

⁶ 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.

- *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.

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. As the United States Supreme 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 that have been accepted for use in *Atkins* cases. See generally *Adaptive Behavior Instruments* at 187–98; *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases* at 117–18.

The clinical diagnosis of deficits in adaptive functioning is *not* a wholly subjective assessment. In a clinical assessment of deficits in adaptive behavior, mental health professionals use standardized measures. AAIDD Manual at 47; DSM-5 at 37. 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 four 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 would be incorrect for a court to conclude that the assessment of adaptive functioning is wholly subjective when done according to the accepted clinical standards.

A person is considered to have deficits in adaptive behavior when he or she demonstrates a significant limitation in one of the three skill domains. AAIDD Manual at 47 (defining “significant” as two standard deviations below the

⁷ The four contemporary scales are the Adaptive Behavior Diagnostic Scale (Pearson, Patton & Mruzek, 2016); 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 & Saulnier, 2016). 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. *Standards for Educational and Psychological Testing* at 93 (“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.”).

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”).

B. “Relatedness” Is Not a Distinct Hurdle in the Test for Intellectual Disability.

The diagnostic criteria for intellectual disability are not evaluated separately, in disjunctive inquiries, but 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 (“Clinical judgment is essential.”). Importantly, the requirement that the deficits in adaptive behavior must be “related” to the impairments in intellectual functioning does not alter the normal assessment. 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 conditions. The most obvious of those conditions include physical disabilities that impair sensory abilities (*e.g.*, blindness or deafness). As explained above, adaptive behavior is the manifestation of intelligence applied to everyday problems. DSM-

5 uses the term “adaptive reasoning” to express this idea. In this sense, intelligence and adaptive behavior are intertwined in everyday life.⁹

The current clinical consensus is that it would be erroneous to treat intellectual disability as inconsistent with personality disorders because both diagnoses may occur concurrently. *See Moore*, 137 S. Ct. at 1051 (noting that requiring a person “to show that his adaptive deficits were not related to a personality disorder” would be a “depart[ure] from clinical practice” (internal quotation marks and citation omitted)). To the contrary, persons with intellectual disability are three to four times more likely to have concurrently 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 does not rule out the possibility that a person **also** has 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

⁹ *See generally* James C. Harris & Stephen Greenspan, *Definition and Nature of Intellectual Disability*, in *Handbook of Evidence-Based Practices in Intellectual and Developmental Disabilities* 11 (Nirbhay N. Singh ed., 2016); Marc J. Tassé, James C. Harris & Stephen Greenspan, *DSM-5: Diagnosis of Intellectual Disability and the “Relatedness” Phrase*, 42 Psychol. in Intell. & Developmental Disabilities / Autism Spectrum Disorders, no. 2 at 20 (Winter 2016).

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); see also *Moore*, 137 S. Ct. at 1051 (“The existence of a personality disorder or mental-health issue, in short, is not evidence that a person does not also have intellectual disability.” (internal quotation marks omitted)). Clinical practice does not require this creation of a false dichotomy between mental illness and intellectual disability, which mental health professionals recognize may coexist. 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”).

II. The Assessment of Deficits in Adaptive Functioning Should Not Be Distorted.

Any diagnosis of intellectual disability should rely on factors that are consistent with the current diagnostic consensus of mental health professionals. In order to avoid distorting the assessment of deficits in adaptive functioning, a proper test for evaluating intellectual disability should recognize the limits of an approach that (1) focuses on perceived strengths rather than demonstrated deficits

or (2) emphasizes atypical behavior or behavior in a controlled setting rather than behavior in a setting where the individual must make adaptive choices.

A. Intellectual Disability Can and Should Be Diagnosed Where There Are Sufficient Deficits in Adaptive Functioning, Even If the Individual Has Relative Strengths in Other Areas.

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. It is incorrect to assume that any demonstration of relative competence disqualifies one from having intellectual disability. On the contrary, intellectually disabled persons can exhibit strengths or competencies relative to their deficits in other areas. *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 et al., *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).

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** conclusive evidence that a person does not have intellectual disability. AAIDD Manual at 45 (“[A]daptive skill limitations often coexist with strengths.”); *see also Moore*, 137 S. Ct. at 1050 (cautioning against “overemphasiz[ing] . . . perceived adaptive strengths” and noting with citation to the AAIDD Manual and DSM-5 that “the medical community focuses the adaptive-functioning inquiry on adaptive *deficits*”); *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 American Association of Mental Retardation Manual)).

The reality of mixed competencies can sometimes conflict with stereotypes of persons with intellectual disability that portray these individuals as comprehensively deficient. One scholar has explained the risk created by failing to appreciate mixed competencies:

[Relative] 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 121.¹⁰

B. Clinical Norms Caution Against Relying on a Person’s Adaptive Functioning in Prison or in Other Controlled Settings.

The professional consensus and clinical norms require a focus on typical behavior when assessing an individual’s functioning. Indeed, 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. Moreover, clinical norms caution against relying on a person’s adaptive functioning in prison or in other controlled settings, especially when data from non-controlled settings is available. As the

¹⁰ As a more general matter, courts should avoid crediting lay stereotypes about intellectual disability. 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). Moreover, 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).

United States Supreme Court recognized in its opinion in this case, clinicians “caution against reliance on adaptive strengths developed ‘in a controlled setting,’ as a prison surely is.” *Moore*, 137 S. Ct. at 1050; *see id.* (quoting DSM-5 for the proposition that “[a]daptive functioning may be difficult to assess in a controlled setting (*e.g.*, prisons, detention centers); if possible, corroborative information reflecting functioning outside those settings should be obtained”).¹¹ Proper evaluation of adaptive functioning requires collecting records and information regarding an individual’s functioning over time and in disparate settings.¹²

CONCLUSION

There is a consensus among the mental health professions about how to properly diagnose persons with intellectual disability. 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 the Supreme Court’s decision in *Hall*, mental health professionals interpret IQ scores using appropriate clinical judgment, including the acceptance of the

¹¹ If there is not a significant sample size of behavior in non-controlled settings as an adult (for example, if an individual was incarcerated for a capital crime at age 18), then data concerning adaptive behavior in controlled settings may be the only data available and thus should be used, albeit cautiously, when conducting an evaluation. That said, the limits of such data should be expressed by the evaluator and considered by courts and other consumers of the evaluation.

¹² *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 . . .”).

standard error of measurement. The use of outdated diagnostic criteria, refusal to interpret IQ scores using clinical standards, inclusion of non-clinical factors to diagnose intellectual disability, and methodological errors in assessing adaptive functioning 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' accepted clinical standards.

The diagnosis of intellectual disability in all 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. For the foregoing reasons, the position of the applicant should be sustained.

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CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that this brief complies with the word limitations of Texas Rule of Appellate Procedure 9.4 because it contains 4,048 words.

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CERTIFICATE OF SERVICE

Pursuant to Texas Rule of Appellate Procedure 11(d), the undersigned hereby certifies that true and correct copies of the foregoing 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 Applicant, and the accompanying Notice of Filing, were served on November 1, 2017, by sending the same via the e-Filing system to the following parties:

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