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EX PARTE BLAINE MILAM

ON APPLICATION FOR POST-CONVICTION WRIT OF HABEAS CORPUS IN CAUSE NO. CR-09-066 IN THE 4TH JUDICIAL DISTRICT COURT OF RUSK COUNTY

BRIEF OF AMICI CURIAE THE ARC OF THE UNITED STATES, THE ARC OF TEXAS, DISABILITY RIGHTS TEXAS, AND THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES IN SUPPORT OF THE APPLICATION FOR A WRIT OF HABEAS CORPUS

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**Applications for pro hac vice admission forthcoming*

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Cases

Atkins v. Virginia,
536 U.S. 304 (2002) ..... *passim*

Ex parte Briseño,
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Brumfield v. Cain,
135 S. Ct. 2269 (2015) 14

In re Cathey,
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City of Cleburne v. Cleburne Living Center,
473 U.S. 432 (1985) 2

Hall v. Florida,
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Ex parte Long,
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Moore v. Texas,
137 S. Ct. 1039 (2017) ..... *passim*

Moore v. Texas,
139 S. Ct. 666 (2019) ..... *passim*

Petetan v. State,
622 S.W.3d 321 (Tex. Crim. App. 2021) 4, 8, 10

United States v. Roland,
281 F. Supp. 3d 470 (D.N.J. 2017) 15

Statutes and Constitutions

124 Stat. 2643 § 2 1

U.S. Const. Amend. VIII 3, 4, 8

Tex. R. App. P. 11 1

Other Authorities

A.B. Silverstein, *Short Forms of Individual Intelligence Tests*, 2 PSYCH. ASSESSMENT 3, 9 (1990) 11

Alan S. Kaufman & Elizabeth O. Lichtenberger, *Assessing Adolescent and Adult Intelligence* 23 (3d ed. 2006) 5, 10

Alan S. Kaufman, Susan Engi Raiford, & Diane L. Coalson, *Intelligent Testing with the WISC-V* 230 (2016) 5, 24

American Educational Research Association, Standards for Educational and Psychological Testing 152 (2014 ed. 2014) 12

Anne Anastasi & Susana Urbina, *Psychological Testing* 296 (7th ed. 1997) 5, 10

APA, *Diagnostic and Statistical Manual of Mental Disorders* 35–37 (5th ed., text rev. 2022) ..... *passim*

Caroline Everington et al., *Challenges in the Assessment of Adaptive Behavior of People Who Are Incarcerated*, in THE DEATH PENALTY AND INTELLECTUAL DISABILITY 201, 202 (Edward A. Polloway ed., 2015) 13

Cecil R. Reynolds & Daneen A. Milam, *Challenging Intellectual Test Results*, in COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 311, 330 (David Faust ed., 6th ed. 2012) 6, 19

Daniel Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 APPLIED NEUROPSYCH. 124, 132 (2009) 12, 14

Felicity Sedgewick et al., AUTISM AND MASKING: HOW AND WHY PEOPLE DO IT, AND THE IMPACT IT CAN HAVE 30 (2021) 22

Gilbert S. Macvaugh & Mark D. Cunningham, Atkins v. Virginia: *Implications and Recommendations for Forensic Practice*, 37 J. PSYCHIATRY & LAW 131, 142 (2009) 15, 17, 18, 21

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) 19

James R. Dudley, Confronting the Stigma in Their Lives: Helping People with a Mental Retardation Label 74-76 (1997) 21

James W. Ellis, Caroline Everington, & Ann M. Delpha, *Evaluating Intellectual Disability: Clinical Assessments in Atkins Cases*, 46 Hofstra L. Rev. 1305, 1403 (2018) ..... *passim*

Karen L. Salekin, et al., *Offenders with Intellectual Disability: Characteristics, Prevalence, and Issues in Forensic Assessment*, 3 J. MENTAL HEALTH RES. IN INTEL. DISABILITIES 97, 110 (2010) 6, 20, 21

Karen L. Salekin, Gilbert S. Macvaugh, III & Timothy J. Derning, *Relevance of Other Assessment Instruments*, in THE DEATH PENALTY AND INTEL. DISABILITY 305, 311 (Edward A. Polloway ed., 2015) 21

Lisa Whipple Drozdick et al., *The Wechsler Adult Intelligence Scale – Fourth Edition and the Wechsler Memory Scale – Fourth Edition* in *Contemporary Intellectual Assessment* 197, 197-207 (Dawn P. Flanagan and Patti L. Harrison eds. 3d ed. 2012) 23

Marc J. Tassé, *Adaptive Behavior Assessment and Diagnosis of Mental Retardation in Capital Cases*, 16 APPLIED NEUROPSYCH. 114, 119 (2009) 13

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 INTEL. & DEV. DISABILITIES 291, 291-92, 297 (2012) 10, 12

Martha E. Snell et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 INTEL. & DEV. DISABILITIES 220, 221 (2009) 14, 20, 21

Matthew H. Scullin, *Large State-Level Fluctuations in Mental Retardation Classifications Related to Introduction of Renormed Intelligence Test*, 111 AM. J. MENTAL RETARDATION 322, 332 (2006) 14

Pearson Assessments, https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Cognition-%26-Neuro/Wechsler-Adult-Intelligence-Scale-%7C-Fifth-Edition/p/P100071002.html (last visited June 12, 2024) 23

Randy G. Floyd, Ryan L. Farmer, W. Joel Schneider, & Kevin S. McGrew, *Theories and Measurement of Intelligence* in 1 AMERICAN PSYCHOLOGICAL ASSOCIATION HANDBOOK OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 385, 413 (Laraine Masters-Glidden ed. in chief, Leonard Abbeduto, Laura Lee McIntyre, Marc J. Tassé eds. 2021) 5, 26

Robert B. Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (rev. & updated ed. 1993) 21

Robert L. Schalock et al., AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 1 (12th ed. 2021) ..... *passim*

Robert L. Schalock et al., AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 95-96 (10th ed. 2010) 12

Robert L. Schalock et al., *The Renaming of* Mental Retardation*: Understanding the Change to the Term* Intellectual Disability, 45 INTEL. & DEV. DISABILITIES 116 (2007).....1

Robert L. Schalock & Ruth Luckasson, CLINICAL JUDGMENT 15, 38 (2d ed. 2014) 16

Robert L. Schalock & Ruth Luckasson, *Intellectual Disability, Developmental Disabilities, and the Field of Intellectual and Developmental Disabilities*, in AMERICAN PSYCHOLOGICAL ASSOCIATION HANDBOOK OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 31, 32 (Laraine Masters-Glidden ed. in chief, Leonard Abbeduto, Laura Lee McIntyre, Marc J. Tassé eds. 2021) 9

STATEMENTS OF INTEREST OF AMICI[1]

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. 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. 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, including by law, and that courts and administrative agencies employ scientific principles for the diagnosis of intellectual and developmental disabilities. The Arc has appeared as amicus curiae in a variety of cases involving intellectual disability and the death penalty, including *Atkins v. Virginia,* 536 U.S. 304 (2002), *Hall v. Florida,* 134 S. Ct. 1986 (2014), and *Moore v. Texas,* 137 S. Ct. 1039 (2017).[2]

The Arc of Texas is a state affiliate of The Arc of the United States. The Arc of Texas similarly promotes, protects, and advocates for the human rights and self-determination of Texans with intellectual and developmental disabilities.

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[1] Pursuant to Tex. R. App. P. 11, Amici represent that no counsel for any party to the underlying litigation has authored this brief in whole or in part, and no counsel for a party or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than Amici or their counsel have made a monetary contribution to the preparation or submission of this brief. *See* Tex. R. App. P. 11(c). Amici further certify that copies of this brief were served on all parties to this action. *See* Tex. R. App. P. 11(d). Amici also represent that they conferred with counsel for the parties in advance of submitting this brief and no party objected to Amici's submission or participation in this matter.

[2] Amici use the term "intellectual disability" in place of "mental retardation" except where directly quoting others. Although the latter term appears in some recorded evidence and relevant case law (in light of its historical use in clinical settings), it is offensive to many persons and has been replaced by more appropriate terminology. As the United States Supreme Court explained in *Hall v. Florida*, "[p]revious opinions of this Court have employed the term 'mental retardation.' This opinion uses the term 'intellectual disability' to describe the identical phenomenon." 134 S. Ct. 1986, 1990 (2014) (citing Rosa's Law, 124 Stat. 2643 § 2 (changing entries in the U.S. Code from "mental retardation" to "intellectual disability")). *See also* Robert L. Schalock et al., *The Renaming of* Mental Retardation*: Understanding the Change to the Term* Intellectual Disability, 45 INTEL. & DEV. DISABILITIES 116 (2007) (explaining that changing terminology does not result in a substantive change to the definition).

Disability Rights Texas ("DRTx") is the federally-mandated protection and advocacy agency for the State of Texas, whose purpose is to protect and advocate for the legal and human rights of individuals with disabilities. DRTx's mission is to help people with disabilities understand and exercise their rights under the law, ensuring their full and equal participation in society. For over forty years, DRTx has accomplished its mission by providing direct legal assistance to people with disabilities, protecting the rights of people with disabilities through the courts and justice system, and educating and informing policymakers about issues that impact the rights and services for people with disabilities, including people with intellectual disabilities in the criminal justice system.

The American Association on Intellectual and Developmental Disabilities ("AAIDD"), founded in 1876, is the nation's oldest and largest organization of professionals in the field of intellectual disability. Through its professional journals, conferences, and book publishing, AAIDD works diligently to advance scientific understanding of intellectual disability. Primarily focused on clinical, psychological, scientific, educational, and habilitative issues, the Association also has a longstanding interest in legal issues that affect the lives of people with intellectual disability. AAIDD has appeared as amicus curiae in a variety of cases involving mental disability, including cases as diverse as *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985), and *Atkins v. Virginia*, 536 U.S. 304 (2002). AAIDD has formulated the most widely accepted clinical definition of intellectual disability. 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.

* * *

In keeping with the United States Supreme Court's repeated holdings that courts must do so, Amici submit this brief to emphasize the necessity of using the appropriate clinical methodology in diagnosing intellectual disability. To do otherwise risks the execution of individuals with intellectual disability in violation of the Eighth Amendment.

SUMMARY OF ARGUMENT

In *Atkins v. Virginia*, 536 U.S. 304 (2002), the United States Supreme Court held that executing defendants with intellectual disability violates the Eighth Amendment's ban on cruel and unusual punishment. Subsequently, in *Hall v. Florida*, 134 S. Ct. 1986 (2014), in accord with the clinical consensus, the United States Supreme Court rejected an arbitrary cutoff for intelligence quotient ("IQ") scores in making the intellectual disability determination and emphasized the importance of courts' adherence to the appropriate clinical standards in their analysis. In *Moore v. Texas*, 137 S. Ct. 1039 (2017) (hereinafter "*Moore I*"), the Supreme Court held that the Eighth Amendment's prohibition on cruel and unusual punishments requires that adjudications of intellectual disability in death penalty cases be "informed by the views of medical experts" and that the non-clinical factors adopted in *Ex parte Briseño*, 135 S.W.3d 1 (Tex. Crim. App. 2004) may no longer be used because they create an unacceptable risk that persons with intellectual disability will be executed.

Following the Supreme Court's lead, this Court has held that Texas courts "must be informed by the current medical diagnostic framework for assessing intellectual disability" when determining whether a person has intellectual disability. *Petetan v. State*, 622 S.W.3d 321, 357 (Tex. Crim. App. 2021); *Moore I*, 137 S. Ct. at 1044. Courts must insist on the use of the clinical framework in evaluating *Atkins* claims. Otherwise, they risk violating the Eighth Amendment and unconstitutionally sentencing individuals to death. Amici offer their guidance on these issues.

As Amici explain further herein, an intellectual disability diagnosis requires (1) significant impairment in intellectual functioning; (2) significant impairment in adaptive functioning (in conceptual, social, and/or practical skills); and the (3) onset of the disability during the individual's developmental period. *See* Robert L. Schalock et al., AAIDD, *Intellectual Disability: Definition,*

Classification, and Systems of Supports 1, 5 (12th ed. 2021) ("AAIDD 2021 Manual"); APA, *Diagnostic and Statistical Manual of Mental Disorders* 35–37 (5th ed., text rev. 2022) ("DSM-5-TR"). The third prong of the diagnosis—onset during the developmental period—is usually a fairly straightforward assessment. The first two prongs of the diagnosis sometimes require more exacting consideration. Thus, it is essential to follow clinical standards in order to prevent an incorrect diagnosis.

The first prong of the diagnosis typically begins with an IQ test. The IQ test and score must be valid in order to substantiate significant impairments in intellectual functioning. Alan S. Kaufman & Elizabeth O. Lichtenberger, *Assessing Adolescent and Adult Intelligence* 23 (3d ed. 2006); Anne Anastasi & Susana Urbina, *Psychological Testing* 296 (7th ed. 1997). The WAIS-IV (as defined below) or Stanford-Binet testing instruments are preferred because they have been rigorously tested and provide a robust, full scale IQ score. In *Atkins* evaluations, using partial scores, even from preferred tests, is inappropriate because part scores necessarily exclude important components of tests that have been developed for their intended use in their entirety. *See* Alan S. Kaufman, Susan Engi Raiford, & Diane L. Coalson, *Intelligent Testing with the WISC-V* 230 (2016); *see* Randy G. Floyd, Ryan L. Farmer, W. Joel Schneider, & Kevin S. McGrew, *Theories and Measurement of Intelligence* in 1 AMERICAN PSYCHOLOGICAL ASSOCIATION HANDBOOK OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 385, 413 (Laraine Masters-Glidden ed. in chief, Leonard Abbeduto, Laura Lee McIntyre, Marc J. Tassé eds. 2021). In this case, the State's evaluator chose to rely on a partial score and ignore the full scale IQ score, despite the mandate of experts in the diagnosis of intellectual disability that requires evaluators to use the full scale IQ score. In cases such as this one, courts must reject the use of part scores to diagnose

or rule out intellectual disability because some individuals may have intellectual deficits in areas not reflected in the part scores alone.

The second prong of the diagnosis requires an evaluation to substantiate significant impairment in adaptive functioning. In the criminal context, impairment in adaptive functioning is ascertained by evaluating information about the individual's adaptive behaviors before they were incarcerated. Clinicians should use an accepted adaptive behavior instrument, review all available records (such as school and medical records), and interview parties who know the individual. However, stereotypes about physical characteristics, behavior, or language abilities can negatively impact the accuracy of the evaluation and result in underdiagnosis of individuals with intellectual disability who may not fit the preconceived mold. James W. Ellis, Caroline Everington, & Ann M. Delpha, *Evaluating Intellectual Disability: Clinical Assessments in Atkins Cases*, 46 Hofstra L. Rev. 1305, 1403 (2018) (hereinafter "Evaluating Intellectual Disability"); Karen L. Salekin, et al., *Offenders with Intellectual Disability: Characteristics, Prevalence, and Issues in Forensic Assessment*, 3 J. MENTAL HEALTH RES. IN INTEL. DISABILITIES 97, 110 (2010). Further, the focus of the second prong concerns *deficits* in adaptive behavior, not strengths; most individuals with intellectual disability are able to complete certain tasks. Cecil R. Reynolds & Daneen A. Milam, *Challenging Intellectual Test Results*, in COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 311, 330 (David Faust ed., 6th ed. 2012). Here, the State's evaluator misused clinical judgment and relied upon an isolated strength—reading ability—to rule out the possibility that the defendant may have intellectual disability. This approach is contrary to the long-established clinical framework used to diagnose intellectual disability. While evaluators may use valid clinical judgment in making an assessment, they cannot use stereotypes or isolated strengths to rule out a

diagnosis of intellectual disability. Courts must insist that experts and evaluators in individual cases adhere to the clinical framework mandated in *Hall*, *Moore I*, and *Moore II*.

By staying informed of clinical best practices and recent findings from experts in the intellectual disability sphere, courts can ensure accurate intellectual disability diagnoses that protect the Constitutional rights guaranteed by *Atkins* and its progeny.

The remainder of this brief offers guidance with respect to applying relevant professional and medical standards for diagnosing intellectual disability, and identifies the ways in which the habeas court's assessment in this case failed to adhere to those standards. It will discuss the three prongs of an intellectual disability diagnosis and common pitfalls in clinical diagnosis that can be avoided by following clinical standards and best practices.

As with any field of scientific inquiry, the clinical understanding of intellectual disability has been refined over time through continuing, rigorous study and analysis. Amici respectfully offer their expertise on the appropriate clinical methodology for diagnosing intellectual disability and the habeas court's reliance on and endorsement of reasoning inconsistent therewith.

ARGUMENT

I. The Eighth Amendment Forbids the Execution of Individuals with Intellectual Disability and Requires Consideration of Appropriate Clinical Standards.

The United States Supreme Court has unequivocally held that "the Eighth and Fourteenth Amendments to the Constitution forbid the execution of persons with intellectual disability." *Hall*, 134 S. Ct. at 1990 (citing *Atkins*, 536 U.S. at 321). In applying the Supreme Court's directive, courts must make clinically sound decisions regarding whether a particular individual has intellectual disability and "must be informed by the current medical diagnostic framework for assessing intellectual disability." *Petetan v. State*, 622 S.W.3d 321, 357 (Tex. Crim. App. 2021); *see also Moore I*, 137 S. Ct. at 1044 ("As we instructed in *Hall*, adjudications of intellectual disability should be 'informed by the views of medical experts.' That instruction cannot sensibly be read to give courts leave to diminish the force of the medical community's consensus.") (internal citations omitted); *Moore v. Texas*, 139 S. Ct. 666, 669 (2019) (hereinafter "*Moore II*") (reiterating the importance of "the medical community's diagnostic framework").

As will be discussed further in this brief, proper analysis and assessment of whether an individual has intellectual disability requires courts to be informed by the medical community's diagnostic framework, including ensuring that determinations are informed by relevant medical and scientific literature and findings, as well as by clinicians' ethical standards and guidelines. *Hall*, 134 S. Ct. at 2000 ("It is the Court's duty to interpret the Constitution, but it need not do so in isolation. The legal determination of intellectual disability . . . is informed by the medical community's diagnostic framework."); James W. Ellis, Caroline Everington, & Ann M. Delpha, Evaluating Intellectual Disability, at 1316 (2018) (citing *Moore I*, 137 S. Ct. at 1044) ("*Hall* and *Moore* emphasize that the Eighth Amendment requires adhering to the contemporary clinical understanding of intellectual disability that is reflected in the clinical literature and in the

judgments by the professional associations of those who study and work in the field of intellectual disability.").

II. Overview of Intellectual Disability: A Diagnostic Road Map

As defined by the AAIDD and the American Psychiatric Association ("APA"), intellectual disability requires three elements: (1) significantly impaired intellectual functioning; (2) significant adaptive behavior deficits in conceptual, social, and/or practical skills; and (3) onset of the disability during the individual's developmental period. *See* AAIDD 2021 Manual at 5; DSM-5-TR at 35–37; Robert L. Schalock & Ruth Luckasson, *Intellectual Disability, Developmental Disabilities, and the Field of Intellectual and Developmental Disabilities*, in AMERICAN PSYCHOLOGICAL ASSOCIATION HANDBOOK OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 31, 32 (Laraine Masters-Glidden ed. in chief, Leonard Abbeduto, Laura Lee McIntyre, Marc J. Tassé eds. 2021). AAIDD's definition of intellectual disability is widely accepted, and is used to diagnose intellectual disability in a variety of contexts, such as eligibility for educational services and disability benefits. *E.g.*, Evaluating Intellectual Disability, at 1325 n. 96, 1326 ("[T]he definitional models for legislation, as well as the forms of the definition that will be encountered most frequently by courts, are the formulations adopted by [AAIDD] . . . the application of these definitions may 'come before the courts in cases involving such issues as special education or community services'").

In *Atkins*, *Hall*, and *Moore I*, the Supreme Court expressly recognized the clinical definition of intellectual disability, and relied on it as the appropriate definition for courts to use in assessing whether an individual facing a death sentence qualifies for a diagnosis of intellectual disability. *Atkins*, 122 S. Ct. at 2250; *Hall*, 134 S. Ct. at 1994; *Moore I*, 137 S. Ct. at 1044; *see also In re Cathey*, 857 F.3d 221 (5th Cir. 2017) (applying *Moore I*); *Moore II*, 139 S. Ct. at 668;

Petetan, 622 S.W.3d at 361; *Ex parte Long*, 2023 Tex. Crim. App. Unpub. LEXIS 309, *4 (Tex. Crim. App. June 28, 2023) (applying *Moore I* and *Moore II*).

The Supreme Court's opinions in *Atkins*, *Hall* and *Moore I* establish that this clinical definition of intellectual disability is the correct definition and framework to use in evaluating claims of intellectual disability made by capital defendants. Each prong of the diagnostic process for intellectual disability is discussed further below.

A. Prong One: Significantly Impaired Intellectual Functioning

The clinical community agrees that whenever possible, the starting point for addressing prong one and measuring intellectual function is a *valid* IQ test and score. *See* Alan S. Kaufman & Elizabeth O. Lichtenberger, *Assessing Adolescent and Adult Intelligence* 23 (3d ed. 2006); Anne Anastasi & Susana Urbina, *Psychological Testing* 296 (7th ed. 1997).

An IQ score measures an individual's performance on a battery of standardized tests in comparison to a reflective demographic sample in terms of gender, race, and age. Evaluating Intellectual Disability, at 1347–48. Generally, an IQ score of 100 equates to approximately average intelligence, with about fifteen points in either direction representing one standard deviation. *Id.* at 1348. To support a finding of intellectual disability, an IQ score must fall at or below two standard deviations from the mean of the test. *Id.* Between 2 and 3 percent of the population has IQ scores that would meet that threshold or fall below it. 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 INTEL. & DEV. DISABILITIES 291, 298 (2012).

Importantly, not all IQ tests are equal. Certain types of tests are more widely accepted than others, and courts should be wary of IQ tests that have not been accepted by the medical community. The AAIDD 2021 Manual identifies individually administered, standardized tests that yield a "full scale IQ score" for measuring general intellectual function as the best practice for

intellectual disability diagnosis. AAIDD 2021 Manual at 44. Even so, some clinicians will either administer or score only a portion of the full standardized IQ test, often with the goal of saving time for the evaluator. However, there is a "strong consensus amongst psychologists and other clinicians that [short tests or partial scores] cannot be used as a substitute for a full assessment of intelligence in matters of significance." Evaluating Intellectual Disability, at 1355. In other words, the use of a short form test is "definitely not legitimate," if any decision or diagnosis in the legal or clinical realm is to be made on the basis of the results. *Id.* (*quoting* A.B. Silverstein, *Short Forms of Individual Intelligence Tests*, 2 PSYCH. ASSESSMENT 3, 9 (1990)).

The two most widely accepted tests for measuring intelligence are the Wechsler Adult Intelligence Test—4th Edition ("WAIS-IV") and the Stanford Binet—Fifth Edition ("SB-5"). The WAIS-IV and the SB-5 each consist of a series of subtests that measure multiple dimensions of intelligence based on contemporary research and an increasing sophistication in psychological measurement. Evaluating Intellectual Disability, at 1348–57. These tests have undergone extensive reliability and validity verification and have been normed on populations including people with intellectual disability. *Id.* at 1351–52 ("Each of the psychometric instruments used to measure intelligence has been pretested and normed on the relevant populations prior to its publication . . . including individuals with intellectual disability").

Although the WAIS-IV and SB-5 have been rigorously constructed and validated, the tests' creators have explained—and the Supreme Court has acknowledged—that they are inherently imprecise, and results must be read "not as a single fixed number, but as a range." *Hall*, 572 U.S. at 712. After taking this Standard Error of Measurement into account, "there is a consensus among psychologists that the *Full Scale* score [of either of these tests] is the most reliable indicator of the individual's level of intelligence." Evaluating Intellectual Disability, at 1353 n. 193 (emphasis

added). Given that the WAIS-IV and the SB-5 are the gold standard of IQ testing, their use in the diagnosis of intellectual disability is mandated by best clinical practices. *Id*; *see* American Educational Research Association, Standards for Educational and Psychological Testing 152 (2014 ed. 2014) ("validity and reliability/precision considerations are paramount").

B. Prong Two: Significantly Impaired Adaptive Functioning

The second prong of the definition of intellectual disability relates to an individual's adaptive functioning, that is, the problems an individual has functioning in everyday life. Evaluating Intellectual Disability, at 1329. Whenever possible, clinicians should use a formal instrument designed to measure adaptive behavior as a primary source to assess an individual's adaptive functioning. While "no single information element or source is ever sufficient to diagnose" intellectual disability, an adaptive functioning assessment requires a careful analysis of available information about adaptive deficits by clinicians with experience in diagnosing intellectual disability. Daniel Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 APPLIED NEUROPSYCH. 124, 132 (2009); AAIDD 2021 Manual at 37 ("Intellectual developmental disorder . . . is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains."); *see also* DSM-5-TR at 13.

Clinicians (and courts reviewing the work of those clinicians) must therefore assess behavior deficits through a "wide-ranging inquiry," including but not limited to an adaptive behavior test, to determine whether there are "sufficient limitations in [an] individual's functioning under ordinary circumstances." Evaluating Intellectual Disability, at 1332. Noticeably, the diagnostic assessment does not focus on potential or maximum performance, but on everyday functioning. *See* Marc J. Tassé et al., *The Construct of Adaptive Behavior: Its Conceptualization, Measurement, and Use in the Field of Intellectual Disability*, at 291–92, 297 (2012) (citing Robert

L. Schalock et al., AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 95–96 (10th ed. 2010)); *and see* AAIDD 2021 Manual, at 101–03 (maintaining everyday function, or "human functioning", as the focal point of this assessment). The goal of this inquiry is to assess "how an individual performed (or failed to perform) tasks in general society." Evaluating Intellectual Disability, at 1334; *see also Moore I*, 137 S. Ct. at 1050. Thus, in the context of criminal defendants, such an assessment necessarily requires gathering information on the individual from before they were incarcerated. Indeed, as the Supreme Court noted in *Moore I*, "[c]linicians, however, caution against reliance on adaptive strengths developed in a controlled setting, as a prison surely is." *Moore I*, 137 S. Ct. at 1050; *Moore II*, 139 S. Ct. at 670–71. This makes sense, as "correctional settings remove virtually all personal control from the individual . . . practical behaviors pertinent to the diagnosis cannot be demonstrated." Caroline Everington et al., *Challenges in the Assessment of Adaptive Behavior of People Who Are Incarcerated*, in THE DEATH PENALTY AND INTELLECTUAL DISABILITY 201, 202 (Edward A. Polloway ed., 2015); Marc J. Tassé, *Adaptive Behavior Assessment and Diagnosis of Mental Retardation in Capital Cases*, 16 APPLIED NEUROPSYCH. 114, 119 (2009) ("the prison setting is an artificial environment that offers limited opportunities for many activities and behaviors defining adaptive behavior.").

Likewise, with respect to impaired adaptive functioning, clinicians focus on what an individual *cannot* do, rather than on the adaptive strengths an individual may also possess. *Moore I*, 137 S. Ct. at 1043 (explaining that "the medical community focuses the adaptive-functioning inquiry on adaptive *deficits*") (emphasis in original); *Moore II*, 139 S. Ct. at 670–71. With assistance and support, many individuals with intellectual disability can secure and maintain employment, live in an apartment, handle money, navigate public transportation, maintain personal relationships, and drive a car. Evaluating Intellectual Disability, at 1403–04, nn. 380–83. Such

"documented outcomes contrast sharply with the incorrect stereotypes" of total incompetence that surround people with intellectual disabilities, and have no bearing on the adaptive behavior analysis, which should focus only on the individual's deficits. *See* Martha E. Snell et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 INTEL. & DEV. DISABILITIES 220, 221 (2009); *Moore I*, 137 S. Ct. at 1043; *Brumfield v. Cain*, 135 S. Ct. 2269, 2281 (2015).

Simply put, intellectual disability is "a condition, not a number." *Hall*, 572 U.S. at 723. People with intellectual disability have a wide range of deficits (and strengths). Courts must avoid reliance on scattered strengths and stereotypes in an *Atkins* evaluation. Doing otherwise violates the holdings of *Hall*, *Moore I*, and *Moore II*, and increases the risk that an individual with intellectual disability will be executed.

C. Prong Three: Onset During the Developmental Period

For the third prong of an intellectual disability diagnosis, clinicians must determine whether the intellectual and adaptive functioning deficits manifested during the individual's developmental years. *See* DSM-5-TR at 43 ("All criteria must be fulfilled by history or current presentation."). A clinician evaluating an adult must of necessity engage in a retrospective assessment by gathering available information from a variety of records and from people who knew the individual in their developmental years. However, such an assessment does not require "that there have been IQ tests or formal assessments of adaptive deficits while the individual was a child." Evaluating Intellectual Disability, at 1338. Indeed, while evidence of intellectual disability must exist during the developmental period, many adults who meet the IQ and adaptive functioning requirements for an intellectual disability diagnosis may never have received a formal diagnosis as children or young adults. Daniel Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 APPLIED NEUROPSYCH. 124, 124 (2009); *see also* Matthew H.

Scullin, *Large State-Level Fluctuations in Mental Retardation Classifications Related to Introduction of Renormed Intelligence Test*, 111 AM. J. MENTAL RETARDATION 322, 332 (2006) (discussing adults whose deficits satisfy the first two prongs for intellectual disability but who never received formal testing in childhood).

III. Characteristics of Intellectual Disability: The Importance of a Clinically Informed, Comprehensive Evaluation

As experts in the field have noted, adherence to the appropriate diagnostic framework requires adherence to clinical judgment and professional ethics. Evaluating Intellectual Disability, at 1316 (citing *Moore I*, 137 S. Ct. at 1044). If clinicians use invalid principles in making a clinical judgment, and do not follow professional ethical guidelines and best practices, they risk misdiagnosing or under-diagnosing individuals with intellectual disability.

Federal courts have recognized that "[c]linical judgment is not simply an expert's opinion," and is "different from either ethical or professional judgment based on one's professional ethics or standards." *United States v. Roland*, 281 F. Supp. 3d 470, 478 (D.N.J. 2017); *see* AAIDD 2021 Manual at 83–85, 101. Rather, clinical judgment is "a special type of judgment rooted in a high level of clinical expertise and experience" that "emerges directly from extensive data and is based on training, experiences, and specific knowledge of the person and his or her environment." *Roland*, 281 F. Supp. 3d at 478; *see* AAIDD 2021 Manual at 83–85, 101. Put differently, clinical judgment is sound reasoning, grounded in a high level of clinical knowledge, applied to the relevant facts and situation presented. It is essential that clinical judgment is based on empirical assessments, rather than mere observations. Gilbert S. Macvaugh & Mark D. Cunningham, Atkins v. Virginia: *Implications and Recommendations for Forensic Practice*, 37 J. PSYCHIATRY & LAW 131, 142 (2009) (hereinafter "Macvaugh & Cunningham") ("[A]n examiner might simply conclude that the defendant "does not seem mentally retarded," independent of IQ score, effort

testing, and structured adaptive behavior assessment. Such . . . methods lack scientific rigor and are not appropriate expressions of clinical judgment.").

While clinicians must be "given latitude" to conduct any necessary evaluation and report on their findings, courts must also be cautious. Evaluating Intellectual Disability, at 1416 (collecting sources). They must "be certain that the clinician is basing his or her conclusion on an empirical and fully documented assessment." *Id.*, rather than on stereotypes, hunches, or a seat-of-the-pants decision. *See* Robert L. Schalock & Ruth Luckasson, CLINICAL JUDGMENT 15, 38 (2d ed. 2014).

Accordingly, courts adjudicating an intellectual disability claim must grant clinicians sufficient latitude to conduct the necessary individualized assessment and report their findings; confirm that those clinicians acted with the requisite standard of care, exercised the requisite level of clinical judgment, and adhered to the ethical standard prescribed by the medical community; and must ensure that the evaluator did not substitute or insert stereotyping or *ad hoc* judgments for sound clinical assessment and analysis.

Courts tasked with determining whether a defendant has intellectual disability must avoid certain pitfalls that will otherwise increase the likelihood of error in an intellectual disability finding. Those pitfalls include an emphasis on stereotypes or preconceived notions with respect to how individuals with intellectual disability may present, and the use of partial, rather than full scale, IQ scores—all factors that permeated the habeas court's underlying findings in this case and poised the habeas court's analysis.

A. Categorical Terms May Provide Some Guidance, But Are Not Definitive

When assessing intellectual disability, clinicians sometimes employ categories organized according to the magnitude of the supports needed by a person with intellectual disability, using the terms "mild," "moderate," "severe," and "profound." AAIDD 2021 Manual at 53; DSM-5-TR

at 39–41. These terms are not always used consistently, which may lead to confusion, and these inconsistent usages often cause readers to jump to conclusions or form preconceptions about a person's limitations that may not accurately reflect the situation presented. The lack of uniformity in the usage of these terms can prevent relevant parties from understanding their clinical context, and may cause observers to ground their judgments within preconceived locutions of the terms. Thus, these terms merit both further discussion and scrutiny by courts considering their usage.

The "moderate," "severe," and "profound" categories encompass people whose disability is often immediately apparent, likely due to atypical facial features or other physical differences. *See* Macvaugh & Cunningham, at 142. Individuals in these groups almost always require extensive supports with even the most basic of tasks such as communication, feeding, dressing, bathing, and toileting. DSM-5-TR at 39–41. Only about 15 percent of people with intellectual disability have deficits so extreme that they qualify for a category other than "mild." *Id.* at 38. In light of their intense support needs, individuals falling into these categories are rarely if ever subject to criminal prosecution. Macvaugh & Cunningham, at 142.

People with "mild" intellectual disability account for the vast majority—approximately 80 to 90 percent—of the population of people with intellectual disability. Snell, at 220. Because people with mild intellectual disability usually lack obvious physical indicators of a disability and have specific strengths alongside their weaknesses, they tend to blend in more with the general population, particularly to a casual observer. *Id.* While people with mild intellectual disability may be able to live in the community without extensive supports, their abilities do not diminish the reality of their very real and substantial disability. Evaluating Intellectual Disability, at 1327–28. In other words, the term "mild" in the context of intellectual disability can be misleading, as it

refers to a level of impairment that is only "mild" in relation to the other levels of severity, which are termed "moderate," "severe," and "profound."

Most criminal defendants with intellectual disability have what is termed as "mild" intellectual disability. Macvaugh & Cunningham, at 142. This is the population that the Supreme Court focused on in its decision in *Atkins* itself. The Court noted that while people with intellectual disability frequently know right from wrong and may be competent to stand trial, they "by definition 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." *Atkins*, 536 U.S. at 318. The Supreme Court concluded that while "their deficiencies do not warrant an exemption from criminal sanctions . . . they do diminish their personal culpability." *Id.*

B. Clinicians Must Focus on Deficits in Diagnosing Intellectual Disability

As mentioned above, however, people with intellectual disability have both strengths and weaknesses (as do people without intellectual disability). AAIDD 2021 Manual at 1 ("within an individual, limitations often coexist with strengths."). A focus on deficits in adaptive functioning in the second prong of the intellectual disability diagnosis "begins with the universally recognized fact that every individual who has intellectual disability also has things that he or she has learned to do, and can do whether with or without assistance." Evaluating Intellectual Disability, at 1394. These abilities, however, "cannot preclude the diagnosis of intellectual disability." *Id.* at 1394, n. 346. While this fact is well-documented by clinicians, it challenges societal expectations that are based on stereotypes about the abilities of people with intellectual disability, which are often formed around people with moderate and severe intellectual disability. *See* Macvaugh & Cunningham, at 142 ("[T]hose with mild [intellectual disability] who become involved in the criminal justice system typically do not exhibit stereotypical physical or behavioral characteristics

commonly associated with severe [intellectual disability]."). Indeed, certain "strengths [of individuals with intellectual disability] may confound a layperson or a professional with limited clinical experience with individuals who have mild [intellectual disability]." *Id.*

Moreover, as explained above, any strengths a person with intellectual disability may have do not somehow *negate* the deficits they must also have. When diagnosing intellectual disability, strengths are not weighed against deficits, and they do not preclude a diagnosis of intellectual disability. Cecil R. Reynolds & Daneen A. Milam, *Challenging Intellectual Test Results*, in COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 311, 330 (David Faust ed., 6th ed. 2012) (An individual with intellectual disability "cannot be disqualified from a diagnosis of [intellectual disability] based upon scattered strengths or skills."). As the Supreme Court held in *Moore I*, the only relevant diagnostic criterion is whether the individual has deficits at the level that would support an intellectual disability diagnosis. *Moore I*, 581 U.S. at 15; *see also* 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) ("[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 intellectual disability is, by definition, a condition characterized by deficits.").

Here, the habeas court erred in accepting the state's assertion that the defendant's strength in reading somehow negated his deficits, an approach that is specifically barred in the medical community's framework of intellectual disability diagnosis.

C. Pervasive Stereotypes Regarding Intellectual Disability Increase the Likelihood that People with Intellectual Disability Will Be Unconstitutionally Executed.

Despite the Supreme Court's clear mandate that an intellectual disability determination must use clinical diagnostic criteria, stereotypes about how people with intellectual disability look and behave have misled some courts in determinations relating to intellectual disability. *See Moore I*, 581 U.S. at 18 (explaining how the "the medical profession has endeavored to counter lay stereotypes of the intellectually disabled" and that such "stereotypes, much more than medical and clinical appraisals, should spark skepticism."). The tendency to use stereotypes and preconceived notions when considering people with intellectual disability comes from the "impulse to measure actual individuals against our own, conjured vision of what people with intellectual disability are like." Evaluating Intellectual Disability, at 1403.

One such stereotype is the erroneous belief that all individuals with intellectual disability can be identified by readily-observable physical behaviors and traits that would mark them as people with intellectual disability. Clinicians have made clear that we cannot *see* the offender with intellectual disability any more obviously than we can *see* the offender without it: "There are no labels on their backs, and there are often no obvious signs that they are impaired enough to warrant attention." Karen L. Salekin et al., *Offenders with Intellectual Disability: Characteristics, Prevalence, and Issues in Forensic Assessment,* 3 J. MENTAL HEALTH RES. IN INTEL. DISABILITIES 97, 110 (2010). Nevertheless, clinicians know that "underneath what appear to be typical offenders lie true differences in cognitive abilities." *Id.* And contrary to the views of many laypeople, most people with mild intellectual disability are "physically indistinguishable from the general population." Snell, at 220.

Another common stereotype is that there are some strengths that automatically disqualify someone from receiving a diagnosis of intellectual disability. People with intellectual disability

may have isolated strengths or skills, such as skill in reading, that are not within the *typical* range of skills for people with the disability. Nonetheless, these individuals do qualify for a diagnosis if they also have the requisite deficits. *See* Karen L. Salekin, Gilbert S. Macvaugh, III & Timothy J. Derning, *Relevance of Other Assessment Instruments*, in THE DEATH PENALTY AND INTEL. DISABILITY 305, 311 (Edward A. Polloway ed., 2015) ("[F]or any IQ score there is a symmetrical range of possible expected achievement scores which, whether reported in terms of standard scores or [grade equivalents], can be large. Achievement scores that are above predicted levels based on measured IQ scores will occur with some degree of regularity for individuals with mild [intellectual disability]." (internal quotation omitted)).

While there are no "definite behavioral features" specifically associated with mild intellectual disability, people with intellectual disability often have a desire to please, as well as increased naivete, gullibility, and suggestibility. Snell, at 220, 226. The combination of these traits "may increase one's risk of making poor decisions" *Id.* at 226. And while these traits are not limited to people with mild intellectual disability, those individuals generally do not have access to the disability services system, which could "assist them in learning to avoid victimization and provide help if victimization occurs." *Id.* at 227.

A further complication is that people with intellectual disability who have relatively higher IQs frequently "mask" their intellectual disability through various behavioral patterns or adjustments in an attempt to "deny the stigma of the label of intellectual disability." Snell, at 226; *see also* Robert B. Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (rev. & updated ed. 1993); James R. Dudley, Confronting the Stigma in Their Lives: Helping People with a Mental Retardation Label 74–76 (1997); Robert L. Schalock & Ruth Luckasson, Clinical Judgment 37 (2d ed. 2014) ("[I]t is more common for individuals with

intellectual disability to 'fake good' to hide their intellectual disability" in order to convince others they are "more competent then they are."); *and see* Felicity Sedgewick et al., AUTISM AND MASKING: HOW AND WHY PEOPLE DO IT, AND THE IMPACT IT CAN HAVE 30 (2021) (identifying examples of adjustments in physical appearance and presentation as masking, such as changes in an individual's posture, eye contact, or voice). People often try to mask their disability by over-reporting abilities and using *hidden supporters* to do tasks they cannot manage alone. For example, a person might appear to *own* a lawn care company, but their spouse keeps the schedule, does all the accounting, and plans the appointments and route for the day. Courts should beware a clinician's reliance on masking behaviors, stereotypes, or isolated strengths to deny a valid diagnosis of intellectual disability. *See Moore I*, 581 U.S. at 18; *Moore II*, 139 S. Ct. at 679. The three-prong test for intellectual disability adopted by the Supreme Court encapsulates the Court's essential observation in *Hall* that intellectual disability is "a condition, not a number." *Hall*, 572 U.S. at 723.

This Court should decline to adopt findings that oversimplify the task of diagnosing intellectual disability by endorsing reliance on clinically unsound factors—whether explicit or implicit—such as preconceived notions or stereotypes about the appearance, behavior, or abilities of people with intellectual disability.

D. Part Scores are Inappropriate as a Substitute for Full Scale IQ Tests When Diagnosing Intellectual Disability

The Wechsler Adult Intelligence Scale ("WAIS") series of intelligence tests meets the high technical standards of quality called for by experts in the field of psychometrics. However, the use of a part score that includes only a portion of the information contained in the full scale score on a WAIS test is inappropriate for the diagnosis of intellectual disability. These scores, such as the General Ability Index ("GAI") relied upon in this case, are both unreliable and unacceptable as a

substitute for the full scale score in diagnosing intellectual disability because part scores do not appropriately evaluate overall intellectual functioning.

The WAIS-IV is universally considered one of the "most reliable" intelligence tests in use today.[3] Evaluating Intellectual Disability, at 1353 n. 193 (citations omitted). It is designed to measure multiple aspects of overall intellectual functioning. To do so, it employs multiple subtests that measure distinct aspects of an individual's intellectual functioning. Lisa Whipple Drozdick et al., *The Wechsler Adult Intelligence Scale – Fourth Edition and the Wechsler Memory Scale – Fourth Edition* in *Contemporary Intellectual Assessment* 197, 197–207 (Dawn P. Flanagan and Patti L. Harrison eds. 3d ed. 2012).[4]

The result of the ten standard WAIS-IV subtests considered together is the full scale intelligence quotient score ("FSIQ"). Drozdick et al., at 200. The FSIQ is considered by evaluators and clinicians in making most mental functioning assessments and is used in the first prong of the definition of intellectual disability. AAIDD 2021 Manual at 28 ("In reference to determining significant limitations in intellectual functioning, a full scale IQ score should be used.").

Sometimes an individual's ability in each subtest area comprising the FSIQ is roughly the same, and as a result, the person will have similar scores on all of these different subtests. This consistency of subtest scores was once thought to be the norm. *See* Floyd et al., at 413. However, more recent scholarship has clearly shown that scattered scores, which occur when the person has

[3] The publisher has announced that the WAIS-V will be released in September 2024. Pearson Assessments, https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Cognition-%26-Neuro/Wechsler-Adult-Intelligence-Scale-%7C-Fifth-Edition/p/P100071002.html (last visited June 12, 2024).

[4] These subtests include Vocabulary, Similarities, Information, Comprehension, Digit-Span, Arithmetic, Letter-Number Sequencing, Block Design, Matrix Reasoning, Visual Puzzles, Figure Weights, Picture Completion, Coding, Symbol Search and Cancellation. Because some subtests are alternates of or done in addition to the standard subtests, not every subtest is administered in every assessment. Drozdick et al., at 200.

very different areas of strengths and weaknesses, are much more common than previously thought. *Id.* (discussing the fact that scatter among scores is "common").

Some of the subtests in the WAIS can be combined into a "part score" (also called an "index score"). A part score is the aggregate of the results of some, but not all, of the subtests of the WAIS. That aggregate is intended to measure only one specific aspect of intellectual functioning. *See* Drozdick et al., at 199–206. The GAI is one such part score and includes the subject's verbal and perceptual reasoning abilities.

Recent literature from the authors of the Wechsler test series rejects the use of part scores when subtest scores vary substantially from one another. A guidebook for the fifth edition of the Wechsler Intelligence Scale for Children, (the WISC-V)—a test closely related to the WAIS—specifically cautions *against* the substitution of the GAI for the FSIQ:

> We believe the [GAI] is most informative when reported with the FSIQ and the Cognitive Proficiency Index . . . . Working memory and processing speed [measured by the subtests in the Cognitive Proficiency Index] have proven again and again to be critical components of overall intellectual ability, and excluding them generally results in a less comprehensive score with reduced construct coverage and predictive validity. In most cases, *the main utility of the [GAI] is as a companion score, not a standalone measure of intellectual ability*.

Kaufman, Engi Raiford, Coalson, *Intelligent Testing with the WISC-V*, at 230 (internal citations omitted, emphasis added).

Other authorities in psychometrics also disagree with using part scores when confronted with subtest variation. *See, e.g.*, Floyd et al., at 413 ("We know that the long-standing practice of routinely invalidating IQ based on part score variability is not sound, and that discrepant part scores are common . . . . [T]here is little supporting evidence for this practice and accumulating counterevidence."). Experts in the diagnosis of intellectual disability also firmly reject the use of part scores in this manner. AAIDD 2021 Manual at 28 ("[T]here is no reason to question the

validity of the [FSIQ], even in individual cases where there is significant factor/part score variability.").

When the clinician's task is to assess someone for *intellectual disability*, the use of a part score such as the GAI can mislead a factfinder and create a false conclusion in diagnosing or ruling out intellectual disability. AAIDD 2021 Manual at 28 ("Part scores should not be used in determining whether the individual's level of intellectual functioning meets the 'significant limitations in intellectual functioning' criterion for a diagnosis of [intellectual disability]."); Floyd et al., at 412–13 ("Current evidence supports use of a comprehensive [FSIQ] when making decisions about [intellectual disability], regardless of discrepancies between part scores.").

Further, the use of part scores as a substitute for the FSIQ when diagnosing intellectual disability is inappropriate because intellectual disability requires significant deficits in *intellectual functioning*. All humans use multiple intellectual skills to navigate the world, including far more than just the verbal and processing skills measured by the GAI:

> Intellectual functioning is a broader term than either intelligence or intellectual abilities . . . . The term intellectual functioning incorporates the common definitional characteristics of intelligence (such as reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, learning quickly, and learning from experience), the abilities currently assessed by standardized intelligence tests, and the consensus view that intellectual functioning is influenced by other human functioning dimensions and by systems of supports.

AAIDD 2021 Manual at pp. 102–03.[5]

The habeas court erred by accepting the substitution of a part score, thereby eliminating the measurement of some of the components of overall intellectual functioning. This practice is

[5] The American Psychiatric Association agrees with this definition of intellectual functioning. DSM-5-TR at 38 (noting that a diagnosis of intellectual disability requires "deficits in general mental abilities" which include "intellectual functions involving reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding"); *see also* Drozdick et al., at 200 (explaining that the GAI should not be substituted for the FSIQ because working memory and processing speed "are important contributors to intelligence.").

not in keeping with the medical community's diagnostic framework, and so could incorrectly rule out an intellectual disability diagnosis. Experts in intellectual disability diagnosis require a full scale IQ score because some people with intellectual disability may have relative strengths in verbal and perceptual reasoning skills, but have such poor memory and processing speed that their FSIQ falls more than two standard deviations below the mean, thus meeting the requirement for the first prong of the intellectual disability diagnosis.

The GAI is only a partial measure of someone's overall intellectual functioning because it ignores the results from the subtests measuring working memory and processing speed. The information that the GAI partial score lacks is critical to a full assessment. Removing or ignoring some of the subtests in order to eliminate scores that may appear to be outliers is not a proper use of clinical judgment when the specific inquiry concerns the individual's overall intellectual functioning. Someone's ability to remember and process information correctly and in a timely fashion is integral to an accurate measure of intellectual functioning.

Where there is significant scatter in an individual's scores, experts in the diagnosis of intellectual disability base their evaluation and conclusions on *more* information, not less. *See* Floyd et al., at 413. Basing professional conclusions on the FSIQ score is the best practice because the evaluator can consider the full range of strengths and weaknesses in an individual's intellectual functioning profile.

Clinicians must know, and carefully use, the correct information to address the question they are being asked to answer. They must also be fully aware of all the relevant scholarship and guidelines regarding an accurate assessment for that condition. *Testing Standards* at 152 ("Tests and inventories that meet high technical standards of quality are a necessary but not a sufficient condition for the responsible administration and scoring of tests and interpretation and use of test

scores. A professional conducting a psychological assessment must complete the appropriate education and training, acquire appropriate credentials, adhere to professional ethical guidelines, and possess a high degree of professional judgment and knowledge.").

Experts in testing may make suggestions about alternative methods of test interpretation, but such suggestions cannot override the knowledge and experience of experts in the field of intellectual disability when evaluating an individual for the condition. Professionals who have devoted their careers to the study, diagnosis, care, and treatment of people with intellectual disability are the most qualified to determine what information is required, and, in contrast, what is not sufficient to make an accurate and complete evaluation of a claim of intellectual disability. Clinicians must use clinical judgment in their selection of tests for making an evaluation. But clinical judgment is never an excuse for an evaluator to ignore best practices mandated by experts in their field. *See Testing Standards* at 164 ("Standard 10.1 Those who use psychological tests should confine their testing and related assessment activities to their areas of competence[.]").

Experts in the diagnosis of intellectual disability have made clear that the FSIQ score remains the best measure of intellectual functioning because it contains *all* the information necessary to make a diagnosis and courts should be governed accordingly.

CONCLUSION

For the reasons above, Amici recommend reversal of the habeas court's decision and remand for further consideration of the intellectual disability issues consistent with the applicable professional considerations laid out herein.

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I hereby certify that this brief contains a total of 8,125 words, excluding those portions that can be excluded pursuant to the same Rules.

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