No. 19-941

In the
Supreme Court of the United States

BILLY DANIEL RAULERSON, JR.,

Petitioner,

v.

WARDEN,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF OF *AMICI CURIAE* DISABILITY RIGHTS LEGAL CENTER, NATIONAL DISABILITY RIGHTS NETWORK, CENTER FOR PUBLIC REPRESENTATION, GEORGIA ADVOCACY OFFICE, STEPHEN N. XENAKIS, JAMES R. MERIKANGAS, AND STEVEN EIDELMAN IN SUPPORT OF PETITIONER

DONALD B. VERRILLI, JR.
Counsel of Record
ADELE M. EL-KHOURI
MUNGER, TOLLES & OLSON LLP
1155 F Street NW 7th Floor
Washington, D.C. 20004
(202) 220-1100
Donald.Verrilli@mto.com

Counsel For Amici Curiae

TABLE OF CONTENTS

Page

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 1

ARGUMENT 3

I. Intellectual Disability Is A Complex Condition The Diagnosis Of Which Requires Comprehensive Assessment And Clinical Judgment. 3

A. The three criteria for intellectual disability must be assessed together through a clinical assessment by a mental health professional. 4

B. Clinical judgment plays an essential role in the diagnosis of intellectual disability. 9

II. The Beyond A Reasonable Doubt Standard Creates An Unacceptable Risk That Individuals With Intellectual Disability Will Be Executed By Inviting Jurors To Rely On Stereotypes That Are Inconsistent With Accepted Clinical Norms. 11

CONCLUSION 23

APPENDIX 1a

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Addington v. Texas,
441 U.S. 418 (1979) 11

Atkins v. Virginia,
536 U.S. 304 (2002) 1, 13

Brumfield v. Cain,
135 S. Ct. 2269 (2015) 19

Hall v. Florida,
572 U.S. 701 (2014) .....passim

Moore v. Texas,
137 S. Ct. 1039 (2017) .....passim

Moore v. Texas,
139 S. Ct. 666 (2019) 3

STATE STATUTES

Ga. Code Ann. § 17-7-131(c)(3)..... 12

OTHER AUTHORITIES

American Association on Intellectual & Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2012) .....passim

American Association on Intellectual & Developmental Disabilities, *User's Guide To Accompany the 11th Edition of Intellectual Disability: Definition, Classification, and Systems of Supports* (2012) 3

TABLE OF AUTHORTIES
(Continued)

Page(s)

American Educational Research Association, *Standards for Educational and Psychological Testing* (2014) 11

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) .....passim

American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (2017) 11

American Psychological Association, *Specialty Guidelines for Forensic Psychology* (2013) 11

Richard J. Bonnie, *The American Psychiatric Association's Resource Document on Mental Retardation and Capital Sentencing: Implementing* Atkins v. Virginia, 32 J. Am. Academy Psychiatry & Law 304 (2004) 10

Anton Dosen & Jan J. M. Gielen, *Depression in Persons with Mental Retardation: Assessment and Diagnosis*, in Mental Health Aspects of Mental Retardation: Progress in Assessment and Treatment (Robert J. Fletcher & Anton Dosen eds., 1993)..... 16

TABLE OF AUTHORTIES
(Continued)

Page(s)

Robert B. Edgerton, *The Cloak of Competence* (2d ed. 1993) 20

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

Sigan L. Hartley & William E. MacLean, Jr., *Depression in Adults with Mild Intellectual Disability: Role of Stress, Attributions, and Coping*, 114 Am. J. Intell. & Dev. Disabilities 147 (2009) 16

Ruth Luckasson & Robert L. Schalock, *Standards to Guide the Use of Clinical Judgment in the Field of Intellectual Disability*, 53 Intell. & Dev. Disabilities 240 (2015) 10

J. Gregory Olley, *Adaptive Behavior Instruments*, in The Death Penalty and Intellectual Disability (Edward A. Polloway ed., 2015) 7

Steven Reiss & Betsey A. Benson, *Psychosocial Correlates of Depression in Mentally Retarded Adults: I. Minimal Social Support and Stigmatization*, 89 Am. J. Mental Deficiency 331 (1985) 16

TABLE OF AUTHORTIES
(Continued)

Page(s)

Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124 (2009) 22

Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* (2d ed. 2014)..... 9, 10, 18, 22

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

Matthew H. Scullin, *Large State-Level Fluctuations in Mental Retardation Classifications Related to Introduction of Renormed Intelligence Test*, 111 Am. J. Mental Retardation 322 (2006) 22

Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs,* Intell. & Dev. Disabilities 220 (2009)..... 13

Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114 (2009) 7, 13, 17, 21

TABLE OF AUTHORTIES
(Continued)

Page(s)

Marc J. Tassé et al., *The Construct of Adaptive Behavior: Its Conceptualization, Measurement, and Use in the Field of Intellectual Disability*, 117 Am. J. Intell. & Dev. Disabilities 291 (2012)..... 8, 20

Marc J. Tassé & John H. Blume, *Intellectual Disability and the Death Penalty: Current Issues and Controversies* (2018) 4, 9, 10, 11, 18

INTEREST OF *AMICI CURIAE*[1]

Amici curiae are leading disability rights organizations and individual mental disability professionals who are clinicians, scholars, and experts in the field of mental disability.[2]

SUMMARY OF ARGUMENT

In *Atkins v. Virginia*, this Court held that the Eighth Amendment's ban on cruel and unusual punishment forbids the execution of criminal offenders with intellectual disability.[3] 536 U.S. 304, 321 (2002). The Constitution thus proscribes state laws that "'creat[e] an unacceptable risk that persons with intellectual disability will be executed.'" *Moore v. Texas*, 137 S. Ct. 1039, 1044 (2017) ("*Moore I*") (quoting *Hall v. Florida*, 572 U.S. 701, 704 (2014)). Enforcing that fundamental principal requires a level

---

[1] Pursuant to Rule 37.6, *amici* represent that this brief was written by counsel for *amici*, and not by counsel for any party. No outside contributions were made to the preparation or submission of this brief. Pursuant to Rule 37.2, *amici* represent that all parties were provided notice of *amici*'s intention to file this brief at least 10 days before its due date and that the parties have consented to the filing of this brief.

[2] A summary of the qualifications and affiliations of *amici* is provided as an appendix to this brief.

[3] Consistent with current clinical practice, in this brief, unless quoting a source, *amici* use the term "intellectual disability" to refer to what used to be termed "mental retardation." This change in terminology is a result of the stigma associated with the term "mental retardation," and reflects person-first language accepted by the medical community. It is not a change in substance. See Robert L. Schalock et al., *The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability*, 45 Intellectual & Developmental Disabilities 116 (2007).

of procedural rigor adequate to determine whether an individual has intellectual disability. That, in turn, requires courts to focus on "the clinical definitions of" intellectual disability. *Hall*, 572 U.S. at 720.

The "generally accepted, uncontroversial" clinical standards for diagnosing intellectual disability are well-established in the medical profession. *Moore I*, 137 S. Ct. at 1045. It is equally well-established that no single diagnostic criterion proves or disproves intellectual disability, *Hall*, 572 U.S. at 723, and that it is error to rely on lay stereotypes to make these judgments, *Moore I*, 137 S. Ct at 1052.

As the record in this case vividly illustrates, Georgia's outlier standard requiring capital defendants to prove intellectual disability beyond a reasonable doubt allows a jury to find reasonable doubt by relying on one or more mere stereotypes about intellectual disability or on seemingly inconsistent diagnostic evidence—even though, under accepted clinical standards, such evidence would not preclude a diagnosis of intellectual disability. Indeed, because intellectual disability is a complex condition requiring comprehensive assessment of multiple criteria and application of clinical judgment, in many cases it will simply be impossible to prove intellectual disability beyond a reasonable doubt. Georgia's beyond a reasonable doubt standard therefore creates significant risks that individuals with intellectual disability will be executed. For these reasons, *amici* believe that the petition presents a question of exceptional importance meriting this Court's review, and submit this brief to present relevant medical literature that can provide context for this Court's consideration of the case.

ARGUMENT

I. Intellectual Disability Is A Complex Condition The Diagnosis Of Which Requires Comprehensive Assessment And Clinical Judgment.

This Court has repeatedly recognized the validity of the unanimous professional consensus on the criteria applied to diagnose intellectual disability. *Moore I*, 137 S. Ct. at 1045; *Hall*, 572 U.S. at 710-13; see also *Moore v. Texas*, 139 S. Ct. 666, 668 (2019) ("*Moore II*"). The definition of intellectual disability has three elements: (1) significant impairments in intellectual functioning; (2) deficits in adaptive functioning; and (3) onset of the disability before the age of 18. 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 Supports* 27 (11th ed. 2010) ("AAIDD–11"); AAIDD, *User's Guide To Accompany the 11th Edition of Intellectual Disability: Definition, Classification, and Systems of Supports* 1 (2012); see also *Moore II*, 139 S. Ct. at 668 (citing DSM-5 and AAIDD-11).[4] These elements "focus[] on a commonly accepted consensus that has endured for more than half a century." James W. Ellis, Caroline Everington & Ann M. Delpha,

[4] Although the definitions of intellectual disability in the DSM-5 and AAIDD-11 contain minor variations in terminology, they are substantively the same, see James W. Ellis, Caroline Everington & Ann M. Delpha, *Evaluating Intellectual Disability: Clinical Assessments in* Atkins *Cases*, 46 Hofstra L. Rev. 1305, 1323-24 (2018), and the variations are not relevant for purposes of this brief.

Evaluating Intellectual Disability: Clinical Assessments in Atkins Cases, 46 Hofstra L. Rev. 1305, 1323 (2018) [hereinafter "*Clinical Assessments in* Atkins *Cases*"]. The definition takes into account that "[i]ntellectual disability is a multifaceted and complex condition that comes in a wide range of clinical presentations." Marc J. Tassé & John H. Blume, *Intellectual Disability and the Death Penalty: Current Issues and Controversies* 1 (2018) [hereinafter "*Intellectual Disability and the Death Penalty*"].

A. The three criteria for intellectual disability must be assessed together through a clinical assessment by a mental health professional.

The diagnosis of intellectual disability requires a comprehensive assessment of all three diagnostic criteria in conjunction, "based on multiple data points" that "include giving equal consideration to significant limitations in adaptive behavior and intellectual functioning." AAIDD-11 at 28; see also DSM-5 at 39 ("A comprehensive evaluation includes an assessment of intellectual capacity and adaptive functioning; identification of genetic and nongenetic etiologies; evaluation for associated medical conditions (e.g., cerebral palsy, seizure disorder); and evaluation for co-occurring mental, emotional, and behavioral disorders.").

1. *Intellectual Functioning.* The first criterion for intellectual disability requires the individual to have significant limitations in intellectual functioning. Intellectual functioning consists of the ability to reason, make plans, solve problems, think abstractly, comprehend complex ideas, make judgments, and

learn from instruction and experience. DSM-5 at 33, 37; AAIDD-11 at 31.

As this Court recognized in *Hall*, 572 U.S. at 712-13, evaluation of general intellectual functioning customarily involves the use of individually administered, appropriate, comprehensive, standardized IQ tests, DSM-5 at 37; AAIDD-11 at 31.[5] Nevertheless, it is improper clinical practice to use only an IQ test score cutoff to assess general intellectual functioning or to make a determination that a person does not have intellectual disability. See *Hall*, 572 U.S. at 712-13; DSM-5 at 37; AAIDD-11 at 31. In particular, as this Court emphasized in *Hall*, an IQ score derived from a test cannot alone be considered "final and conclusive evidence of a defendant's intellectual capacity, when experts in the field would consider other evidence," and an IQ score "should be read not as a single fixed number but as a range," in part because each IQ test has a standard error of measurement ["SEM"], and the score on any given test "may fluctuate for a variety of reasons." *Id.*

2. *Adaptive Functioning.* The second criterion for intellectual disability requires the individual to have significant limitations in adaptive functioning. Adaptive functioning is the "collection of conceptual, social, and practical skills that have been learned and are performed by people in their everyday lives."

---

[5] "The 'significant limitations in intellectual functioning' criterion for a diagnosis of intellectual disability is an IQ score that is approximately two standard deviations below the mean, considering the standard error of measurement for the specific instruments used and the instruments' strengths and limitations." AAIDD-11 at 31.

AAIDD-11 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.[6] Adaptive functioning is multidimensional across three domains: (1) conceptual skills, including language, reading and writing, and mathematical reasoning; (2) social skills, including interpersonal skills, empathy, and social judgment and problem solving; and (3) practical skills, including personal care, occupational skills, schedules, and task organization. AAIDD-11 at 44; DSM-5 at 37.

To have significant limitations in adaptive functioning, an individual must either have a significant impairment in any one of the domains or a significant impairment overall. AAIDD-11 at 46-47; DSM-5 at 37-38. There is an accepted clinical consensus that intellectual disability can and should be diagnosed when the individual has sufficient *deficits* in adaptive functioning, regardless of whether the individual also has relative *strengths* in social or physical capabilities, either in some adaptive skill areas or even in one aspect of one adaptive skill area.

---

[6] "The purpose of this element of the definition is to make sure that the impairment indicated in psychometric tests actually has a real-world impact on the individual's life and thus is a disabling condition rather than merely a testing anomaly." *Clinical Assessments in* Atkins *Cases* at 1374. Because adaptive functioning is a better indicator of the individual's ability to function in society, the clinical definition classifies levels of severity in intellectual disability according to adaptive functioning rather than IQ score. See DSM-5 at 33 ("The various levels of severity are defined on the basis of adaptive functioning, and not IQ scores, because it is adaptive functioning that determines the level of supports required.").

See AAIDD–11 at 47 ("[S]ignificant limitations in conceptual, social, or practical adaptive skills [are] not outweighed by the potential strengths in some adaptive skills."); DSM–5 at 33, 38 (explaining that adaptive functioning inquiry should focus on "[d]eficits in adaptive functioning"); *Moore I*, 137 S. Ct. at 1050 ("[T]he medical community focuses the adaptive-functioning inquiry on adaptive deficits.").

The assessment of adaptive functioning relies on standardized measures, including detailed neuropsychological testing. AAIDD-11 at 47; DSM-5 at 37; see J. Gregory Olley, *Adaptive Behavior Instruments*, in The Death Penalty and Intellectual Disability 187-98 (Edward A. Polloway ed., 2015).[7] It also requires collecting records and information regarding an individual's functioning over time and in disparate settings. AAIDD-11 at 47; DSM-5 at 37. That information frequently comes from knowledgeable respondents, including the individual's parents, other family members, teachers, employers, and friends, and educational, employment, and medical records. AAIDD-11 at 47; DSM-5 at 37; *Hall*, 572 U.S. at 712 (recognizing "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

[7] The four well-established standardized instruments are Adaptive Behavior Scale - School, Second Edition (ABS-Schools), published by AAIDD, Adaptive Behavior Assessment System - Third Edition (known as the ABAS-3), Scales of Independent Behavior - Revised (known as the SIB-R), and Vineland Adaptive Behavior Scales - Third Edition (known as the Vineland-3). See *Clinical Assessments in* Atkins *Cases* at 1377-78.

histories, behavioral records, school tests and reports, and testimony regarding past behavior and family circumstances").

By contrast, there is widespread clinical consensus *disfavoring* reliance on information provided by the individual herself in assessing adaptive functioning, because numerous studies and clinical experience have shown that individuals with intellectual disability are unreliable in describing or assessing their own abilities, and tend to *overstate* their past and present abilities and accomplishments. See *Clinical Assessments in* Atkins *Cases* (collecting clinical sources); Marc J. Tassé et al., *The Construct of Adaptive Behavior: Its Conceptualization, Measurement, and Use in the Field of Intellectual Disability*, 117 Am. J. Intell. & Dev. Disabilities 291, 296 (2012) [hereinafter "*Construct of Adaptive Behavior*"] (same); AAIDD-11 at 51 ("Self-ratings of individuals—especially those individuals with higher tested IQ scores [within the intellectual disability range]—may contain a certain degree of bias and should be interpreted with caution when determining an individual's level of adaptive behavior.").

3. *Age of Onset.* The third criterion for intellectual disability requires that an individual's deficits be present before the person reaches adulthood—that is, before the age of 18. AAIDD-11 at 6; DSM-5 at 31. "The vast majority of people with the level of intellectual impairment to satisfy the first prong of the definition—and the deficits in adaptive behavior to satisfy the second prong—first experienced their disability in childhood, and for some, the cause can be traced back to their birth or their genetic make-up." *Clinical Assessments in* Atkins *Cases* at 1336-37. "The only individuals who

are excluded from the category by the age of onset requirement are individuals whose disability can be traced to events during adulthood," such as dementia or brain injuries due to post-adolescence accidents. *Id.* at 1337.

B. Clinical judgment plays an essential role in the diagnosis of intellectual disability.

There is also unanimous professional consensus that "[c]linical judgment is essential" to the diagnosis of intellectual disability. AAIDD-11 at 29; see also *id.* at 40 ("It must be stressed that the diagnosis of ID is intended to reflect a clinical judgment rather than an actuarial determination. A fixed point cutoff score for ID is not psychometrically justifiable."); DSM-5 at 37 ("The diagnosis of intellectual disability is based on *both* clinical assessment *and* standardized testing of intellectual and adaptive functions." (emphases added)); see generally Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 15 (2d ed. 2014) [hereinafter "*Clinical Judgment*"]. Clinical judgment is as critical to the assessment of intellectual functioning and age of onset as it is to the assessment of adaptive functioning, particularly for retrospective assessments. See DSM-5 at 37 ("Clinical training and judgment are required to interpret test results and assess intellectual performance."); *Intellectual Disability and the Death Penalty* at 140 (explaining that evaluator must exercise clinical judgment in determining age of onset retrospectively).

Far from being subjective, clinical judgment is "a special type of judgment rooted in a high level of clinical expertise and experience and judgment that emerges directly from extensive training, experience with the person, and extensive data." AAIDD-11 at

29; see also *id.* at 40. Indeed, "[t]he purpose of clinical judgment is to enhance the quality, validity, and precision of the clinician's decision or recommendation in situations related to diagnosis, classification, and planning supports." *Clinical Judgment* at 15. To that end, clinical judgment is rooted in objective criteria, see AAIDD-11 at 90-102, that "provide the basis for valid and precise decisions and recommendations," Ruth Luckasson & Robert L. Schalock, *Standards to Guide the Use of Clinical Judgment in the Field of Intellectual Disability*, 53 Intell. & Dev. Disabilities 240, 247 (2015).

The central role of clinical judgment is also reflected in the professional standards and qualifications for experts testifying in *Atkins* cases. See *Intellectual Disability and the Death Penalty* at 156-57. "In light of the heightened need for reliability in capital sentencing, it is particularly important to promote the highest quality of assessment and to minimize unnecessary variation from accepted professional standards." Richard J. Bonnie, *The American Psychiatric Association's Resource Document on Mental Retardation and Capital Sentencing: Implementing* Atkins v. Virginia, 32 J. Am. Academy Psychiatry & Law 304, 307 (2004) (citation and internal quotation marks omitted). "The expert selected or appointed to conduct mental retardation evaluations in capital cases should be a psychiatrist or psychologist who is qualified by training and experience to make a diagnosis of mental retardation. The testing of intellectual functioning and adaptive behavior should be carried out by clinicians who have the necessary skill and experience." *Id.* What is more, it is up to the experts to make "certain that their testimony and methods

upon which it rests meet the [*Daubert* or other] relevant standards of admissibility." *Intellectual Disability and the Death Penalty* at 151. To that end, "[t]here are a number of professional resources and materials to which all mental health experts involved in an intellectual disability determination *must* refer and adhere," including the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2017) and *Specialty Guidelines for Forensic Psychology* (2013), and the American Educational Research Association's *Standards for Educational and Psychological Testing* (2014). *Id.* (citing sources).

II. The Beyond A Reasonable Doubt Standard Creates An Unacceptable Risk That Individuals With Intellectual Disability Will Be Executed By Inviting Jurors To Rely On Stereotypes That Are Inconsistent With Accepted Clinical Norms.

Because intellectual disability is a complex condition requiring a comprehensive assessment of multiple criteria and application of clinical judgment, proving its existence beyond a reasonable doubt to a lay person will often prove impossible, even when a clinician would have high confidence in the diagnosis. As this Court has said, "even if the particular standard-of-proof catchwords do not always make a great difference in a particular case, adopting a standard of proof is more than an empty semantic exercise." *Addington v. Texas*, 441 U.S. 418, 425 (1979) (citation and internal quotation marks omitted). Indeed, in striking down application of the beyond a reasonable doubt standard to civil commitment proceedings, this Court recognized that

"[t]he subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations." *Id.* at 430.

The same is true here. In practice, Georgia's outlier requirement that an individual prove intellectual disability beyond a reasonable doubt, Ga. Code Ann. § 17-7-131(c)(3), is irreconcilable with the accepted clinical standards for diagnosing intellectual disability. The Georgia pattern jury instructions state that a reasonable doubt can arise from "consideration of the evidence, a lack of evidence, *or a conflict in the evidence*." 2 Georgia Suggested Pattern Jury Instructions-Criminal 1.20.10 (2019) (emphasis added). That standard invites jurors to ignore clinical consensus, allowing them to rely on one or multiple factors that are indisputably inconsistent with the clinical diagnostic standards to find that an individual does not have intellectual disability.

The problem is particularly acute for individuals with "mild" intellectual disability.[8] This Court has left no doubt that "[m]ild levels of intellectual disability, although they may fall outside Texas citizens' consensus, nevertheless remain intellectual

[8] *Amici* do not contend that it would always be impossible for a jury to find that any individual has intellectual disability beyond a reasonable doubt. As documented in the clinical literature, there are individuals who have such profound intellectual disability that they may, for example, not have functional use of objects, be able to communicate only through nonverbal, nonsymbolic communication, and depend on others for all aspects of daily physical care, health, and safety. See DSM-5 at 36. But, as explained above, it is for individuals with non-profound intellectual disability that Georgia's beyond a reasonable doubt standard poses an "unacceptable risk" that individuals with intellectual disability will be executed.

disabilities," and are protected by the *Atkins* right. *Moore I*, 137 S. Ct. at 1051 (citing *Hall*, 572 U.S. at 718-19; *Atkins*, 536 U.S. at 308 &n.3; AAIDD-11 at 153). And clinical literature establishes that "[e]ssentially all the individuals in the criminal justice system—and therefore all the defendants in *Atkins* cases—fall within the same sub-category, 'mild.'" *Clinical Assessments in Atkins Cases* at 1320 (citing Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 117 (2009) [hereinafter "*Adaptive Behavior Assessment*"); see also Martha E. Snell & Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs,* Intell. & Dev. Disabilities 220, 220 (2009) (explaining that the group of people with intellectual disability who have higher IQs make up about 80% to 90% of all individuals with intellectual disability).

This Court need look no further than Mr. Raulerson's case to see that the beyond a reasonable doubt standard invites prosecutors to point to, and juries to find, the meager doubt required by focusing on one or more lay stereotypes or on seemingly inconsistent diagnostic evidence, even though, under accepted clinical standards, such evidence would not preclude a diagnosis of intellectual disability.

1. *First*, the prosecutor in Mr. Raulerson's case urged the jury to find reasonable doubt on the ground that any given IQ test has a standard error of measurement.

> The low score, [the defense expert] wanted you to believe that the score was 75, that if it was below 75, you are

> retarded, but then he admitted that, really, it's 70 to 75, and, in fact, the other book, DSM-4, said approximately 70. He set out that the reason the other one, the American Association for the Mentally Retarded, says 75, the reason they say 75, is because it's approximately 70 plus or minus 5, and he says 75, but he never would acknowledge that when you go plus or minus, that means it could drop down to 65, and that is because psychologists cannot be sure, cannot be certain of IQ. There are too many factors involved. They're discussing the mind, and there is no way to be certain that certain things exist or do not exist. . . . [The defense expert] says that he tested him, and for the most part, the main test, the comprehensive IQ test he says he gave him, was 69 plus or minus 5 points, which means it's just as likely that it was over 70 as it is just as likely that it was under 70. Now he gives five tests. The question is, why the overkill? Why all of those IQ tests if one provides the valid test? I submit it's just simply, if they can come in—If they say it enough times with enough tests, maybe somebody will believe it.

Raulerson v. Terry, No. 05-57 (S.D. Ga. Filed May 2, 2008), ECF No. 31-127 at 143-44.

Yet, as explained above and by this Court, see *supra* 4-5, the clinical diagnostic standards take into account that an IQ score is properly viewed as a

range, not one number. And, in any event, there is unanimous professional consensus that IQ tests alone cannot prove or disprove intellectual disability. See *supra* 4-5; *Hall*, 572 U.S. at 723; DSM-5 at 37; AAIDD-11 at 31.

2. *Second*, the prosecutor in Mr. Raulerson's case also urged the jury to find reasonable doubt on the basis that Mr. Raulerson was depressed and having problems sleeping when he took the IQ tests.

> But keep in mind that certain emotional factors can affect one's ability to take an IQ test or any other test; depression and inability to sleep, being two major ones, and the third one being that, you know, he's in jail awaiting a trial on three counts of murder. These affect IQ scores. . . . Although he tested him many different times, it was all within a couple of months of each other, but the place was the same place each and every time. Although he gave him five tests, every time he gave him that test, he was at the Ware County Jail. Every time he gave him that test, he was depressed, because he didn't treat him for depression. Every time he gave him that test, he was having inability to sleep. . . . The defendant is depressed, not sleeping well, awaiting trial for three murders.

ECF No. 31-127 at 144-46.

But there is a clear clinical consensus that the diagnosis and existence of any form of mental illness in an individual cannot preclude a diagnosis of

intellectual disability. DSM-5 at 31, 39-40; AAIDD-11. There is also abundant clinical literature describing the high incidence of comorbid depression in individuals with intellectual disability. See DSM-5 at 40; *Clinical Assessments in* Atkins *Cases* at 1342 n.151 (citing Anton Dosen & Jan J. M. Gielen, *Depression in Persons with Mental Retardation: Assessment and Diagnosis*, in Mental Health Aspects of Mental Retardation: Progress in Assessment and Treatment 70 (Robert J. Fletcher & Anton Dosen eds., 1993); Sigan L. Hartley & William E. MacLean, Jr., *Depression in Adults with Mild Intellectual Disability: Role of Stress, Attributions, and Coping*, 114 Am. J. Intell. & Dev. Disabilities 147 (2009); Steven Reiss & Betsey A. Benson, *Psychosocial Correlates of Depression in Mentally Retarded Adults: I. Minimal Social Support and Stigmatization*, 89 Am. J. Mental Deficiency 331 (1985)).

Indeed, relying on that clear consensus, this Court in *Moore I* found that "many [people with intellectual disability] also have other mental or physical impairments, for example, attention-deficit/hyperactivity disorder, depressive and bipolar disorders, and autism." 137 S. Ct. at 1051 (citing DSM–5 at 40 ("[c]o-occurring mental, neurodevelopmental, medical, and physical conditions are frequent in intellectual disability, with rates of some conditions (e.g., mental disorders, cerebral palsy, and epilepsy) three to four times higher than in the general population"); AAIDD–11, at 58–63)).

3. *Third*, the prosecutor in Mr. Raulerson's case urged the jury to find reasonable doubt on the ground that the expert interviewed Mr. Raulerson's mother and father to assess his adaptive functioning.

> The other criteria for mental retardation is deficits in social skills or adaptive social behavior, and for that, Dr. Grant interviews the defendant's mother and father, people who have a stake in something that will benefit the defendant, a test that is biased at the very least.

ECF No. 31-127 at 146.

That is also inconsistent with accepted clinical standards. The standardized measures for assessing adaptive behavior involve "obtaining information regarding the individual's adaptive behavior from a person or persons who know the individual well," including family members, teachers, employers, and friends. AAIDD-11 at 47; see *supra* 7-8. Indeed, "[t]he ideal respondents" for purposes of assessing adaptive functioning "are individuals who have the most knowledge of the individual's everyday functioning across settings."). See *Adaptive Behavior Assessment* at 119.

4. *Fourth*, the prosecutor in Mr. Raulerson's case urged the jury to find reasonable doubt based on a slew of lay stereotypes about Mr. Raulerson, including that he had a job, was married, and could keep a secret:

> Another question: "Keeps secrets for more than one day." They said, the parents said, sometimes he does, but we know now from the evidence that for seven months Billy Daniel Raulerson harbored one of the most terrible secrets any person could ever harbor, and that is that he killed three people brutally.

> . . . We know he was married, we know he had a child. We know he worked as a roofer. Dr. Grant kept talking about routine work. He worked as a roofer. He worked as a carpenter on a horse barn that was being built by Andy Taylor. Freddie Hickox indicated that after he worked for him, he went to work with Andy Taylor, building a horse barn, doing carpenter work. He worked for three months in the summer of 1990 for Freddie Hickox, working an inverted routed that Freddie Hickox said he caught on to doing in five minutes, and the very first day there on the job he made the production level. I submit to you that's not retarded.

ECF No. 31-127 at 147-48.

As this Court has recognized, the uniform clinical consensus rejects such incorrect lay stereotypes about what constitutes intellectual disability. *Moore I*, 137 S. Ct. at 1052. Some of these debunked stereotypes are that individuals with intellectual disability: look and talk differently from persons in the general population; are completely incompetent and dangerous; cannot do complex tasks; cannot get a driver's license, buy cars, or drive cars; cannot support their families; cannot offer romantic love or receive romantic love; and cannot acquire vocational and social skills necessary for independent living. *Clinical Judgment* at 42. Other debunked stereotypes are that individuals with intellectual disability cannot: graduate high school, get and keep a job, get married, have children, and manage money. *Intellectual Disability and the Death Penalty* at 6-8.

5. *Fifth*, the prosecutor in Mr. Raulerson's case urged the jury to find reasonable doubt on the ground that Mr. Raulerson had some adaptive strengths, such as the ability to communicate in writing and the ability to tell right from wrong.

> One of the things you'll have is these letters [Mr. Raulerson wrote while he was in jail.] . . . It's a two-page letter about a cooler. It's obvious then that cooler was pretty important to him, but he was able to write a two-page letter about a cooler, and there are some other letters in here. You look at them. Examine the handwriting, the punctuation, the use of words, the sentence structure, and you'll see Billy Daniel Raulerson is not retarded. . . . The defendant knows right from wrong. You heard even Daniel Grant have to admit that. He knows it is wrong to kill. He knows that if he does wrong, he will be punished for it . . . .

ECF No. 31-127 at 150, 156.

Again, this Court has recognized that focusing on an individual's adaptive strengths rather than deficits is a distortion of the clinical diagnostic standards. See *supra* 6-7. "[T]he medical community focuses the adaptive-functioning inquiry on adaptive *deficits*." *Moore I*, 137 S. Ct. at 1050 (citing AAIDD–11 at 47; DSM–5 at 33, 38; *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." (internal quotation marks and citation omitted))).

6. *Sixth*, the prosecutor in Mr. Raulerson's case urged the jury to find reasonable doubt on the basis that Mr. Raulerson pretended to have intellectual disability.

> I submit that what you've got here is, the test results of Lower and Grant are not valid indication of Billy Daniel Raulerson's true IQ. They do not reflect his IQ when he was 26 years of age, because he wasn't motivated, he wasn't trying, he didn't care to try. . . . He lied to the psychologist about this head injury, and if he lied about that, he lied about other things on that psychological report, including faking on or trying not to do well on these tests.

ECF No. 31-127 at 145-46, 151.

That, too, is inconsistent with accepted clinical standards. See *supra* 8. It is well-documented that, rather than "malingering"—or pretending to have intellectual disability—individuals with intellectual disability instead "have a tendency to overestimate their competence and adaptive skills in an effort to appear more capable than they may actually be." *Construct of Adaptive Behavior* at 296; see generally Robert B. Edgerton, *The Cloak of Competence* (2d ed. 1993). That is why "there is a widespread consensus that warns against reliance on self-reports in assessing adaptive functioning for purposes of diagnosing intellectual disability." *Clinical Assessments in* Atkins *Cases* at 1385 & n.315 (citing clinical sources); *Construct of Adaptive Behavior* at

296 ("[V]irtually all experts in the assessment of adaptive behaviors agree with this position.")); AAIDD-11 at 51.

7. *Finally*, the prosecutor in Mr. Raulerson's case urged the jury to find reasonable doubt on the basis that Mr. Raulerson had not been diagnosed as having intellectual disability before he was in prison.

> The burden is on the defendant to prove his mental retardation beyond a reasonable doubt, and they cannot do it because it is not the truth. That reasonable doubt is that the defendant went to the Waycross School System, the Waycross School System, the Ware County School System—nor did anyone else; the Mental Health Center—and no one ever diagnosed him as being mentally retarded until Daniel Grant came along in the summer of 1995. He's sitting in jail a year.

ECF No. 31-127 at 153-54.

Yet there is a well-established medical consensus that, although the disability must have manifested during the developmental period of life, the definition does *not* require that there have been IQ tests or formal assessments of adaptive deficits while the individual was a child. See *Clinical Assessments in* Atkins *Cases* at 1338 & n.138 (citing *Adaptive Behavior Assessment* at 115 ("It should be noted that 'originated during the developmental period' does not preclude making a first time diagnosis of mental retardation when an individual is an adult. The clinician must, however, adequately document that the deficits in intellectual and adaptive functioning

were present before the end of the developmental period."); Matthew H. Scullin, *Large State-Level Fluctuations in Mental Retardation Classifications Related to Introduction of Renormed Intelligence Test*, 111 Am. J. Mental Retardation 322, 331 (2006) ("There is no professionally recognized requirement for a developmental period classification of mental retardation or developmental period IQs in the mental retardation range from childhood to establish mental retardation."); Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124, 124 (2009) ("Persons can, of course, be properly diagnosed as MR as adults even if no official diagnosis can be found over the ages of birth to 18, but evidence must exist that the condition of MR existed before age 18."); *Clinical Judgment* at 37-41).

* * *

There is consensus among mental health professionals, already deemed valid by this Court, about how properly to diagnose individuals with intellectual disability. The diagnostic criteria reflect that intellectual disability is a complex condition characterized by a wide range of clinical presentations. They require a comprehensive assessment of multiple criteria and application of clinical judgment. In many cases, then, a diagnosis of intellectual disability does not reflect uniform evidence or a near-absolute certainty, as required by a burden of proof beyond a reasonable doubt. By requiring capital defendants to prove intellectual disability beyond a reasonable doubt, Georgia invites jurors to ignore this clinical consensus, allowing them to rely on one or multiple factors that are indisputably irreconcilable with the clinical

diagnostic standards to find that an individual does not have intellectual disability. From a professional diagnostic standpoint, then, Georgia's standard of proof creates significant risks that individuals with intellectual disability will be executed in violation of the Eighth Amendment.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for a writ of certiorari.

February 27, 2019

Respectfully submitted,

DONALD B. VERRILLI, JR.
Counsel of Record
ADELE M. EL-KHOURI
MUNGER, TOLLES & OLSON LLP
1155 F Street NW 7th Floor
Washington, D.C. 20004
(202) 220-1100
Donald.Verrilli@mto.com

Counsel For Amici Curiae

APPENDIX

The **Disability Rights Legal Center (DRLC)** is a nonprofit legal organization founded in 1975 to represent and serve people with disabilities. Individuals with disabilities continue to struggle with ignorance, prejudice, insensitivity, and lack of legal protections in their endeavors to achieve fundamental dignity and respect. DRLC assists people with disabilities in obtaining equality of opportunity and maximizing independence via the benefits and protections guaranteed under the Americans with Disabilities Act, the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act, the Unruh Civil Rights Act, and other state and federal laws. DRLC is widely acknowledged as a leading disability public interest organization and it participates in various *amici curiae* efforts in cases affecting the rights of people with disabilities.

The **National Disability Rights Network (NDRN)** is the non-profit membership organization for the federally mandated Protection and Advocacy (P&A) and Client Assistance Program (CAP) agencies for individuals with disabilities. The P&A and CAP agencies were established by the United States Congress to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. There are P&As and CAPs in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories (American Samoa, Guam, Northern Mariana Islands, and the US Virgin Islands), and there is a P&A and CAP affiliated with the Native American Consortium which includes the Hopi, Navajo and San Juan Southern Paiute Nations in the Four Corners region of the Southwest. Collectively, the P&A and CAP

agencies are the largest provider of legally based advocacy services to people with disabilities in the United States.

The **Center for Public Representation (CPR)** is a public interest law firm that has assisted people with disabilities for more than 40 years. CPR uses legal strategies, systemic reform initiatives, and policy advocacy to enforce civil rights, expand opportunities for inclusion and full community participation, and empower people with disabilities to exercise choice in all aspects of their lives. CPR is both a statewide and a national legal backup center that provides assistance and support to public and private attorneys representing people with disabilities in Massachusetts and to the federally funded protection and advocacy programs in each of the States. CPR has litigated systemic cases on behalf of persons with disabilities in more than 20 states and submitted *amici* briefs to the United States Supreme Court and many courts of appeals in order to enforce the constitutional and statutory rights of persons with disabilities, including those involved in the criminal justice system.

The **Georgia Advocacy Office (GAO)** is the appointed Protection and Advocacy System for the State of Georgia. Its mission is to work with and for oppressed and vulnerable individuals in Georgia who are labeled as disabled or mentally ill to secure their protection and advocacy.

Brigadier General (Ret) Stephen N. Xenakis, M.D., L.L.C. is an adult, child, and adolescent psychiatrist and retired from the U.S. Army in 1998 at the rank of Brigadier General. He serves on the Executive Board of the Center for Ethics and Rule of

Law at the University of Pennsylvania Law School, the editorial board of the Journal of the American Academy of Psychiatry and Law, and is an Adjunct Professor at the Uniformed Services of Health Sciences (USUHS) of the military medical department.

James R. Merikangas, M.D. is board certified in both neurology and psychiatry, with more than 45 years experience in the practice of neuropsychiatry. He is currently Clinical Professor of Psychiatry and Behavioral Science at the George Washington University School of Medicine in Washington, D.C. Dr. Merikangas's primary clinical interest is the evaluation and treatment of patients with complex brain-behavior problems. He has been engaged in forensic evaluations in both civil cases and the criminal justice system, with particular expertise in the neural basis of aggressive and violent behavior, and has qualified as an expert witness in many state and federal courts. While on the faculty of the University of Pittsburgh, he was the medical consultant to the Mental Retardation Clinic. As a founding member of the American Academy of Neuropsychiatry, he established guidelines for routine evaluation of patients with complex brain disorders in neuropsychiatry comprised of neurologic examinations, neuroimaging, and neuropsychological evaluations. Dr. Merikangas is a past President of the American Academy of Clinical Psychiatrists, Fellow of the American College of Physicians, Fellow of the American Neuropsychiatric Association, and Distinguished Life Fellow of the American Psychiatric Association. He has won the National Alliance on Mental Illness Distinguished Clinician Award for his contribution to clinical care of people

with neuropsychiatric disorders. He is the author of more than 36 scientific publications, 22 invited book reviews, 8 book chapters, and edited a book entitled Brain-Behavior Relationships.

Steven Eidelman is the H. Rodney Sharp Professor of Human Services Policy and Leadership at the University of Delaware and the co-founder and Faculty Director of The National Leadership Consortium on Developmental Disabilities. He is a past President of the American Association on Intellectual and Developmental Disabilities (AAIDD) and serves as Senior Advisor to the Chairman of Special Olympics International. He also serves as the Executive Director of The Joseph P. Kennedy, Jr. Foundation. His recent efforts have focused on leadership development for practicing intellectual and developmental disability professionals and on implementation of Article 19 of the United Nations Convention on the Rights of Persons with Disabilities, focusing on deinstitutionalization. He was the Pennsylvania state government official in charge when Pennhurst State School and Hospital was closed and has served as an expert witness on Olmstead-based deinstitutionalization litigation. His professional interests focus on professional development of disability professionals and on deinstitutionalization and the development of community supports for people with intellectual disability. He holds an MSW from The University of Maryland, an MBA from Loyola University Baltimore, and a Post-Masters Certificate in the Administration of Social Services from Temple University.