No. 21-782

IN THE

Supreme Court of the United States

RODNEY RENIA YOUNG,

Petitioner,

v.

GEORGIA,

Respondent.

On Petition for Writ of Certiorari to the Supreme Court of Georgia

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

DONALD B. VERRILLI, JR.
Counsel of Record
LEONARDO MANGAT
MUNGER, TOLLES & OLSON LLP
601 Massachusetts Ave. NW
Suite 500E
Washington, DC 20001
(202) 220-1100
Donald.Verrilli@mto.com

Counsel for Amici Curiae

TABLE OF CONTENTS

Page

INTEREST OF AMICI CURIAE 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. GEORGIA'S BEYOND-A-REASONABLE-DOUBT STANDARD VIOLATES THE MEDICAL COMMUNITY'S LONGSTANDING FRAMEWORK FOR DIAGNOSING INTELLECTUAL DISABILITY 4

A. Experts diagnose intellectual disability using three distinctly fact-bound, inherently nuanced criteria 4

B. Experts' clinical judgment is an indispensable ingredient in diagnosing intellectual disability 9

C. Georgia's standard creates an unacceptable risk that people with intellectual disability will be executed by inviting jurors to rely on lay stereotypes and for other clinically improper reasons 11

II. THE PRESENT CASE SPOTLIGHTS THE CONSTITUTIONAL INFIRMITIES WITH GEORGIA'S STANDARD.................. 15

III. GEORGIA'S CHOICES NOT TO REQUIRE THAT INTELLECTUAL DISABILITY BE PROVEN BEYOND A REASONABLE DOUBT ELSEWHERE UNDERSCORES

THE IMPERMISSIBILITY OF ITS USE OF THAT STANDARD IN CAPITAL CASES 17

CONCLUSION 20

ADDENDUM 1a

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Addington v. *Texas*,
441 U.S. 418 (1979) 3, 11, 12

Atkins v. *Virginia*
536 U.S. 304 (2002) 2

Brumfield v. *Cain*,
576 U.S. 305 (2015) 15

Cooper v. *Oklahoma*,
517 U.S. 348 (1996) 17

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

Hill v. *Humphrey*,
662 F.3d 1335 (11th Cir. 2011) 13, 16

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

Moore v. *Texas*,
139 S. Ct. 666 (2019) 4, 13

Raulerson v. *Warden*,
928 F.3d 987 (11th Cir. 2019) 12

Speiser v. *Randall*,
357 U.S. 513 (1958) 19

In re Winship,
397 U.S. 358 (1970) 19

TABLE OF AUTHORITIES
(continued)

Page(s)

STATE CASES

Kim v. *Metropolitan Atlanta Olympic Games Authority*, 489 S.E.2d 372 (Ga. Ct. App. 1997) 19

STATUTES

Ga. Code Ann. § 9-3-73(c)(1) 18

Ga. Code Ann. § 9-3-90(a) 18

Ga. Code Ann. § 9-4-4(a) 19

Ga. Code Ann. § 17-7-131(c)(3) 3, 12

Ga. Code Ann. § 44-5-170 19

STATE REGULATIONS

Ga. Comp. R. & Regs. 160-4-7-.01 18

Ga. Comp. R. & Regs. 160-4-7-.02(1) 18

Ga. Comp. R. & Regs. 160-4-7-.03 18

Ga. Comp. R. & Regs. 160-4-7-.04 18

Ga. Comp. R. & Regs. 160-4-7-.05 18

Ga. Comp. R. & Regs. 160-4-7-.05 Appendix (e) 18

TABLE OF AUTHORITIES
(continued)

Page(s)

OTHER AUTHORITIES

American Association on Intellectual & Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2010).. *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).......................... *passim*

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

Richard J. Bonnie, *The American Psychiatric Association's Resource Document on Mental Retardation and Capital Sentencing: Implementing*.. 10

TABLE OF AUTHORITIES
(continued)

Page(s)

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

Georgia Department of Behavioral Health & Developmental Disabilities, *Application for Intellectual / Developmental Disabilities Services* (2016), https://dbhdd.georgia.gov/document/publication/services-instructionsandapplication12-28-16pdf 18

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

Robert M. Sanger, *IQ, Intelligence Tests, "Ethnic Adjustments" and* Atkins, 65 Am. U. L. Rev. 87 (2015) 5, 6

Timothy R. Saviello, *The Appropriate Standard of Proof for Determining Intellectual Disability in Capital Cases: How High Is Too High?*, 20 Berkeley J. Crim. L. 163 (2015) 9, 11, 12, 13

TABLE OF AUTHORITIES (continued)

Page(s)

Robert L. Schalock et al., *The Renaming of* Mental Retardation*: Understanding the Change to the Term* Intellectual Disability, 45 Intell. & Developmental Disabilities 116 (2007) 2

Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* (2d ed. 2014) 10, 13, 15

Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114 (2009) 14

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 Intell. & Developmental Disabilities 291 (2012) 8

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

INTEREST OF AMICI CURIAE[1]

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

---

[1] According to Supreme Court Rule 37.6, amici affirm that no counsel for a party authored this brief in whole or in part, and that no person or entity other than amici, its members, and its counsel made a monetary contribution intended to fund the preparation or submission of this brief. The parties have consented to the filing of this brief.

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

SUMMARY OF ARGUMENT

In *Atkins* v. *Virginia*, this Court held that the Eighth Amendment's ban on cruel and unusual punishment forbids execution of people with intellectual disabilities.[3] 536 U.S. 304, 321 (2002). The Constitution thus proscribes state laws that "create[] an unacceptable risk that persons with intellectual disability will be executed." *Hall* v. *Florida*, 572 U.S. 701, 704 (2014). Enforcing that fundamental principle requires a level of procedural rigor adequate to determine whether a person has intellectual disability. That, in turn, requires courts to focus on "the clinical definitions of" intellectual disability, as "informed by the medical community's diagnostic framework," *Hall*, 572 U.S. at 720–21.

The "generally accepted, uncontroversial" clinical standards for diagnosing intellectual disability are well-established in the medical profession. *Moore* v. *Texas*, 137 S. Ct. 1039, 1045 (2017) ("*Moore I*"). 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 here confirms, by requiring capital defendants to prove intellectual disability beyond a

---

[3] To comport with contemporary medical practice, amici use the term "intellectual disability" rather than "mental retardation," unless quoting a source. This change in terminology is due to the stigma associated with the term "mental retardation," exemplifies person-first language accepted by the medical community, and is not intended to be a change in substance. *See* Robert L. Schalock et al., *The Renaming of* Mental Retardation*: Understanding the Change to the Term* Intellectual Disability, 45 Intell. & Developmental Disabilities 116, 120 (2007).

reasonable doubt, Ga. Code Ann. § 17-7-131(c)(3)—a standard that no other State has adopted—Georgia allows jurors to find reasonable doubt by relying on one or more stereotypes about intellectual disability or on seemingly inconsistent diagnostic evidence, even though, under accepted clinical standards, such evidence could well support a diagnosis of intellectual disability. Indeed, because experts diagnosing intellectual disability must use their clinical judgment and three distinctly fact-bound, inherently nuanced criteria to diagnose this complex condition, it will be virtually impossible to prove intellectual disability beyond a reasonable doubt in most cases. Georgia's beyond-a-reasonable-doubt standard thus creates a constitutionally unacceptable risk that individuals with intellectual disability will be executed.

Georgia's outlier approach is all the more striking in light of its treatment of intellectual disability in other areas of the law. Georgia does not require that intellectual disability be proven beyond a reasonable doubt in areas ranging from providing services for people with intellectual disability to determining limitations periods for medical-malpractice suits. Only here—when a person's life is at stake—has Georgia chosen to place "almost the entire risk of error" on the person in need of the law's protection. *Addington* v. *Texas*, 441 U.S. 418, 424 (1979).

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. GEORGIA'S BEYOND-A-REASONABLE-DOUBT STANDARD VIOLATES THE MEDICAL COMMUNITY'S LONGSTANDING FRAMEWORK FOR DIAGNOSING INTELLECTUAL DISABILITY

A. Experts diagnose intellectual disability using three distinctly fact-bound, inherently nuanced criteria

This Court has repeatedly instructed that the legal determination of intellectual disability "must be 'informed by the medical community's diagnostic framework.'" *Moore* v. *Texas*, 139 S. Ct. 666, 669 (2019) ("*Moore II*") (quoting *Moore I*, 137 S. Ct. at 1048); *see also Moore I*, 137 S. Ct. at 1044; *Hall*, 572 U.S. at 721. Applying that framework, an expert will diagnose a person with intellectual disability if the following three criteria are met:

1. the person has "significantly subaverage intellectual functioning," or, in other words, intellectual-functioning deficits;
2. the person has "the inability to learn basic skills and adjust behavior to changing circumstances," or, in other words, adaptive-functioning deficits; and
3. the person's intellectual- and adaptive-functioning deficits began "during the developmental period," or, in other words, the age of onset.

Hall, 572 U.S. at 710; *see also Moore I*, 137 S. Ct. at 1045; *Moore II*, 139 S. Ct. at 668; Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 33 (5th ed. 2013) [hereinafter *DSM–5*]; Am.

Ass'n on Intell. & Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Supports* 27 (11th ed. 2010) [hereinafter *AAIDD–11*]; AAIDD, *User's Guide To Accompany the 11th Edition of Intellectual Disability: Definition, Classification, and Systems of Supports* 1 (2012).[4]

1. *Intellectual Functioning Deficits*. The first criterion for intellectual disability asks whether a person has "significantly subaverage" limitations in intellectual functioning. *Hall*, 572 U.S. at 710. Intellectual functioning typically refers to a person's mental capacity, meaning their ability to reason, to learn, and to problem-solve, and clinicians usually measure a person's intellectual functioning using an IQ test. *DSM–5*, *supra*, at 33, 37; *AAIDD–11*, *supra*, at 31. These standardized tests measure a person's ability to learn and to process information by assessing what they have learned over time. *Clinical Assessments*, *supra*, at 1326–29.[5]

These methodologies and the results they produce are, as this Court has recognized, inherently "imprecise." *Hall*, 572 U.S. at 723; *see also* Robert M. Sanger, *IQ, Intelligence Tests, "Ethnic Adjustments"*

---

[4] The definitions of intellectual disability in the DSM–5 and the AAIDD–11 vary in form but not substance. *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) [hereinafter *Clinical Assessments*]. Their variations are not relevant here.

[5] In general, a person has significant limitations in intellectual functioning if the person has an IQ score about 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*, *supra*, at 31.

and Atkins, 65 Am. U. L. Rev. 87, 102 (2015) ("Scientists agree that testing in general, and psychometric testing in particular, is not absolutely precise."). This imprecision is due in part to variations in the tests, the test-takers, and the examiners. *Hall*, 572 U.S. at 713. A test-taker might have, for instance, honed her skills on an earlier test or fortuitously guessed the right answer on another one. *Id.* A test may have been administered incorrectly. *Id.* Or an examiner may have scored a test inconsistently. *Id.* "An IQ score," then, "is an approximation, not a final and infallible assessment of intellectual functioning." *Id.* at 722. This is why strict IQ-score cutoffs to determine whether a person has intellectual-functioning deficits—concluding that a person has intellectual-functioning deficits if they have an IQ score of 70 but not 71, for example—are not clinically proper. *Id.* at 712–13; *see also DSM–5*, *supra*, at 37; *AAIDD–11*, *supra*, at 31.

2. *Adaptive Functioning Deficits*. The second criterion for intellectual disability asks whether a person is unable "to learn basic skills and adjust behavior to changing circumstances." *Hall*, 572 U.S. at 710. This inquiry centers on a person's everyday conceptual skills, including reading, writing, and mathematical skills; everyday social skills, including their interpersonal, problem-solving, and social-judgment skills; and everyday practical skills, including organizational, occupational, and personal-care skills. *AAIDD–11*, *supra*, at 44–45; *DSM–5*, *supra*, at 37. Clinicians conclude a person has adaptive-functioning deficits if the person is significantly impaired either in one or more type of skill (conceptual, social, or practical) or across all of

them. *AAIDD–11*, *supra*, at 46–47; *DSM–5*, *supra*, at 37–38.[6]

As this Court has explained, "the medical community focuses the adaptive-functioning inquiry on adaptive *deficits*." *Moore I*, 137 S. Ct. at 1050; *see also DSM–5*, *supra*, at 33, 38. This means that, for instance, a clinician will conclude that a person has adaptive-functioning deficits if the person is significantly impaired in reading and writing skills, even though the person has strong interpersonal skills. *See AAIDD–11*, *supra*, 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*, *supra*, at 33, 38. Although this focus on deficits over strengths may seem "counterintuitive" to a layperson, an approach that weighs adaptive skills against adaptive deficits "is totally inconsistent with the definition of intellectual disability and with sound diagnostic practice." *Clinical Assessments*, *supra*, at 1336.

Moreover, because the adaptive-functioning inquiry focuses "on the person's ordinary, everyday functioning," it requires clinicians to gather and assess information from across the person's life and from many sources. *Clinical Assessments*, *supra*, at 1333. This information typically comes from a person's records, test results, employment evaluations, and interviews from family, friends,

---

[6] Assessing adaptive functioning also requires relying on standardized measures. *Clinical Assessments*, *supra*, at 1377–78. The four well-established standardized measurements are the Adaptive Behavior Scale – School, Second Edition; Adaptive Behavior Assessment System – Third Edition; Scales of Independent Behavior – Revised; and Vineland Adaptive Behavior Scales – Third Edition. *See id.*

teachers, and employers. *Id.* at 1333–34; *see also AAIDD–11*, *supra*, at 47; *DSM–5*, *supra*, at 37. But expert clinicians caution against relying on information from controlled settings—"as a prison surely is"—because the focus of this inquiry is, again, on a person's everyday abilities. *Moore I*, 137 S. Ct. at 1050. In like manner, experts will not base their diagnoses principally on information from the person himself, for clinical experience and scientific studies confirm that people with intellectual disability "are notoriously unreliable in describing or assessing their own abilities." *Clinical Assessments*, *supra*, at 1384 (collecting sources); *see also* 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 Intell. & Developmental Disabilities 291, 296 (2012) (same); *AAIDD–11*, *supra*, 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 reported with caution when determining an individual's level of adaptive behavior.").

3. *Age of Onset*. The third criterion for intellectual disability asks whether a person's deficits were present "before the age of 18." *Hall*, 572 U.S. at 727; *see also AAIDD–11*, *supra*, at 6; *DSM–5*, *supra*, at 31. Most people with intellectual- and adaptive-functioning deficits "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*, *supra*, at 1336–37. That a person's deficits manifest before the person is 18 years old does not mean, however, that those deficits must be *detected* before then, for there is no requirement "that there have been IQ tests or formal assessments of

adaptive deficits while the individual was a child," because it is often a matter of "happenstance" whether such tests or assessments occur. *Id.* at 1338.

* * *

Though the "phenomenon of intellectual disability has been recognized for centuries," today's definition of intellectual disability "focuses on a commonly accepted consensus that has endured for more than half a century." *Clinical Assessments*, *supra*, at 1323. This modern definition recognizes that intellectual 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*]. So the three diagnostic criteria include distinctly fact-bound and imprecise inquiries and measurements in part because intellectual disability is a multifaceted and complex condition.

B. Experts' clinical judgment is an indispensable ingredient in diagnosing intellectual disability

Just as the expert consensus recognizes the importance of intellectual disability's three diagnostic criteria, it equally recognizes that clinical judgment is "integral to the ultimate diagnosis" of intellectual disability. Timothy R. Saviello, *The Appropriate Standard of Proof for Determining Intellectual Disability in Capital Cases: How High Is Too High?*, 20 Berkeley J. Crim. L. 163, 198 (2015) [hereinafter *Standard of Proof*]; *see also AAIDD–11*, *supra*, at 29; *DSM–5*, *supra*, at 37 ("The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions."). An

expert's 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*, *supra*, at 29, 40. This judgment is rooted in objective criteria, *see id.* 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. & Developmental Disabilities 240, 247 (2015); *see also* Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 15 (2d ed. 2014) [hereinafter *Clinical Judgment*] (noting the "purpose of clinical judgment is to enhance the quality, validity, and precision of the clinician's decision or recommendation").

Indeed, the importance of expert clinical judgment is reflected in the professional standards and qualifications for experts testifying in capital cases that require an assessment of a defendant's intellectual disability. It "is particularly important," the American Psychiatric Association has said, "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. Acad. Psychiatry & L. 304, 307 (2004). Doing so requires selecting experts qualified "by training and experience to make a diagnosis" of intellectual disability, like psychiatrists or psychologists. *Id.* It requires ensuring that they make "certain that their testimony and methods upon which it rests meet the relevant standards of admissibility," like the *Daubert* or *Frye* standards of evidentiary admissibility. *Intellectual Disability and the Death Penalty*, *supra*, at 151.

And it requires mandating that they refer and adhere to certain "professional resources and materials" while making an intellectual-disability diagnosis, like the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2017), its *Specialty Guidelines for Forensic Psychology* (2013), and the American Educational Research Association's *Standards for Educational and Psychological Testing* (2014). *Intellectual Disability and the Death Penalty*, *supra*, at 151 (citing sources).

"No two diagnosticians are the same," however. *Standard of Proof*, *supra*, at 198. Because clinicians bring their "unique individual life experiences, education[,] and training to the work," their clinical judgment is "subjective, and thus will vary between individual mental health professionals who review the same data." *Id.* This Court has recognized as much. Because diagnosing intellectual disability is "to a large extent based on medical 'impressions' drawn from subjective analysis and filtered through the experience of the diagnostician," this Court has observed, it is "very difficult for the expert physician to offer definite conclusions about any particular patient." *Addington*, 441 U.S. at 430.

C. Georgia's standard creates an unacceptable risk that people with intellectual disability will be executed by inviting jurors to rely on lay stereotypes and for other clinically improper reasons

"[A]dopting a standard of proof is more than an empty semantic exercise." *Addington*, 441 U.S. at 425 (quotation marks and citation omitted). It is meant to allocate the risk of error in a manner that is just and respects fundamental constitutional guarantees. *See*

id. Georgia's requirement that a capital defendant prove intellectual disability beyond a reasonable doubt fails on that score. Indeed, capital defendants whose lives may depend on meeting that standard will almost invariably be engaged in an exercise in futility, because the "beyond-a-reasonable-doubt standard requires a level of certainty that mental health experts simply cannot provide." *Raulerson* v. *Warden*, 928 F.3d 987, 1018 (11th Cir. 2019) (Jordan, J., dissenting). A method that relies on inherently imprecise standardized tests, on interviews of family, friends, or teachers about events that happened decades ago, and on nuanced clinical judgment cannot reliably produce a result with the degree of certainty that Georgia law demands. In light of the "subtleties and nuances" of diagnosing intellectual disability that "render certainties virtually beyond reach in most situations," *Addington*, 441 U.S. at 430, Georgia "asks more than the science allows," *Standard of Proof*, *supra*, at 203. By requiring capital defendants to prove their intellectual disability beyond a reasonable doubt, Ga. Code Ann. § 17-7-131(c)(3), Georgia's law creates an unacceptable risk that people with intellectual disability will be executed.

The jury instruction that Georgia employs to implement its beyond-a-reasonable-doubt standard vividly illustrates the risks that such a standard creates. The pattern jury instructions tell jurors that a reasonable doubt "is a doubt based upon common sense and reason" and can arise from, among other things, "a conflict in the evidence." 2 Georgia Suggested Pattern Jury Instructions—Criminal 1.20.10 (4th ed. 2021). That instruction is constitutionally suspect twice over.

First, by instructing jurors that "a conflict in the evidence" is enough to create a reasonable doubt,

Georgia encourages jurors to discard the expert consensus on intellectual disability. Intellectual-disability claims are "incredibly fact-intensive and could devolve into a swearing match between conflicting, and equally qualified, experts," thereby "easily—if not always—creat[ing] reasonable doubt that the defendant is not mentally retarded." *Hill* v. *Humphrey*, 662 F.3d 1335, 1364 (11th Cir. 2011) (Tjoflat, J., concurring in the judgment). So an instruction that "would prevent courts and juries from reaching a conclusion commensurate with the diagnostic methods of the mental health profession"—by allowing conflicts in the evidence to trump clinical certainty—"would be an unconstitutional burden." *Standard of Proof*, *supra*, at 203.

Second, by instructing jurors that a reasonable doubt "is a doubt based upon common sense and reason," Georgia all but invites jurors to rely on "'lay perceptions of intellectual disability' and 'lay stereotypes' to guide assessment of intellectual disability." *Moore II*, 139 S. Ct. 669 (quoting *Moore I*, 137 S. Ct. at 1051–52). Too often, jurors hold unfounded stereotypes about how people with intellectual disability should look and act. For example, jurors may well think that people with intellectual disability cannot financially support themselves, cannot be gainfully employed, or cannot have romantic relationships. *Clinical Judgment*, *supra*, at 42. But these stereotypes are wrong, *id.*, and Georgia's invitation to jurors to use their common sense creates an unacceptable risk that "jurors will—consciously or unconsciously—base their decision on their own stereotyped views of intellectual disability," *Clinical Assessments*, *supra*, at 1399–1407; *see also Moore I*, 137 S. Ct. at 1052 ("Those [lay] stereotypes, much more than medical and clinical appraisals, should spark skepticism.").

These problems are all the more acute for people with "mild" intellectual disability. Someone with mild intellectual disability tends to have comparatively less significant impairments, and therefore may, to a lay person, not appear disabled. *Clinical Assessments*, *supra*, at 1319–20. Even so, "[m]ild levels of intellectual disability," this Court has taught, "remain intellectual disabilities," and "States may not execute anyone in 'the *entire category* of [intellectually disabled] offenders.'" *Moore I*, 137 S. Ct. at 1051 (citation omitted, alteration in original). Indeed, because most people with intellectual disability fall within the category of mild intellectual disability, not profound disability, "[e]ssentially all the individuals in the criminal justice system—and therefore all the defendants in *Atkins* cases—fall within" the mild intellectual disability category. *Clinical Assessments*, *supra*, at 1320 (citing Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 117 (2009)).[7]

---

[7] Amici do not argue that it would always be impossible for jurors to find that any person has intellectual disability beyond a reasonable doubt. As the clinical literature documents, there are people who have such profound intellectual disability that they can communicate through nonverbal or nonsymbolic communication only; that they cannot use objects functionally; or that they depend on others for all aspects of daily physical care, health, and safety. *See DSM–5*, *supra*, at 36. But, as explained above, it is for people with non-profound intellectual disability that Georgia's standard poses an "unacceptable risk" that people with intellectual disability will be executed.

II. THE PRESENT CASE SPOTLIGHTS THE CONSTITUTIONAL INFIRMITIES WITH GEORGIA'S STANDARD

The factual record in this case provides ample confirmation that Georgia's outlier approach to intellectual disability in capital cases poses constitutionally intolerable risks.

First, the state called three of Young's coworkers from a cannery to testify. Young, they testified, was "good at his job," was "one of our best operators" of can-labeling machines, was not "a problem employee," and was "always on time." App. 200a–01a.

This testimony, however, is troubling for two reasons. "[T]he medical community focuses the adaptive-functioning inquiry on adaptive *deficits*." *Moore I*, 137 S. Ct. at 1050 (citing *AAIDD–11*, *supra*, at 47; *DSM–5*, *supra*, at 33, 38). Whether Young was punctual or a model employee hardly disproves intellectual disability, for "intellectually 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." *Brumfield* v. *Cain*, 576 U.S. 305, 320 (2015) (quotation marks and citation omitted).

Relatedly, this testimony plays on discredited stereotypes. *Moore I*, 137 S. Ct. at 1052. Based on testimony that Young was punctual or a good employee, a juror might conclude that Young was not intellectually disabled. But doing so requires relying on unfounded stereotypes about the capabilities of people with intellectual disability. *Clinical Judgment*, *supra*, at 42. A lower standard of proof would not be susceptible to this problem.

Second, Young called his childhood teachers and educators to testify on his behalf. App. 5a, 220a. One witness, the head of the special education department who had personally taught Young, stated that Young was "classified as educable mentally retarded and that was determined by the battery of tests that was given by that child study team." App. 220a–21a. To be classified as such, the department head continued, Young would "have to score within a range of 60 to 69 for the IQ test." App. 220a–21a. Another witness testified that it "was common knowledge that Rodney was functioning as far as his academics [] probably, like, on the third grade level" while Young was in high school. Pet. 6. The jury nevertheless found that Young was not intellectually disabled despite that compelling objective evidence—underscoring the near impossibility of meeting Georgia's outlier standard of proof. *See Humphrey*, 662 F.3d at 1364 (Tjoflat, J., concurring in the judgment) (noting how conflicts among expert testimony "easily—if not always—create reasonable doubt that the defendant is not mentally retarded").

Third, the prosecution leaned heavily on Georgia's reasonable doubt standard in urging the jury to impose a death sentence, and the Georgia Supreme Court likewise upheld the death sentence based on that standard. A "reasonable doubt," the prosecution argued, "is any doubt that leaves your mind wavering, unsettled or unsatisfied." Pet. 7. If "your mind is wavering or unsettled or unsatisfied about the fact that the defense has proven that he is mentally retarded," she remarked again later, "then you have the right to reject this defense and say, the defense has not proven he's mentally retarded beyond a reasonable doubt." Pet. 7. The Supreme Court of Georgia likewise concluded "that Young had failed to prove beyond a rea-

sonable doubt that he was 'mentally retarded,'" "considering the conflicting testimony on the subject." App. 5a (citation omitted).

But to focus on conflicting testimony and on the standard of proof itself is to focus on, again, a level of certainty that science cannot provide. To conclude that these minute reasons are enough to discard scientific consensus on the issue means that, in effect, Georgia's scheme more often than not results in people with intellectual disability being executed. *See Cooper* v. *Oklahoma*, 517 U.S. 348, 369 (1996) ("Because Oklahoma's procedural rule allows the State to put to trial a defendant who is more likely than not incompetent, the rule is incompatible with the dictates of due process.").

III. GEORGIA'S CHOICES NOT TO REQUIRE THAT INTELLECTUAL DISABILITY BE PROVEN BEYOND A REASONABLE DOUBT ELSEWHERE UNDERSCORES THE IMPERMISSIBILITY OF ITS USE OF THAT STANDARD IN CAPITAL CASES

In *Moore I*, this Court concluded that Texas's use of the so-called *Briseno* factors to determine whether people had adaptive-functioning deficits—factors that were medically unsound—was unacceptable because "Texas itself does not follow *Briseno* in contexts other than the death penalty." *Moore I*, 137 S. Ct. at 1052. "Texas," this Court remarked, "cannot satisfactorily explain why it applies current medical standards for diagnosing intellectual disability in other contexts" but "clings to superseded standards when an individual's life is at stake." *Id.* Georgia's beyond-a-reasonable-doubt standard is suspect for the same reasons.

Across diverse areas, like disability services, special-education services, statutes of limitations, declaratory-judgment statutes, and prescription statutes, Georgia does not require proof of intellectual disability beyond a reasonable doubt. For example, Georgia allows a person to obtain intellectual-disability services, like nursing services, equipment, or supplies, if the person has an intellectual disability measured in accordance with accepted clinical standards, not a beyond-a-reasonable-doubt standard. *See* Ga. Dep't Behav. Health & Developmental Disabilities, *Application for Intellectual/Developmental Disabilities Services* 3 (2016), https://dbhdd.georgia.gov/document/publication/services-instructionsandapplication12-28-16pdf.

Similarly, Georgia's regulations for determining whether a student has an intellectual disability for the purposes of a free appropriate public education do not require proof beyond a reasonable doubt. *See* Ga. Comp. R. & Regs. 160-4-7-.01, 160-4-7-.02(1), 160-4-7-.03, 160-4-7-.04, 160-4-7-.05. Instead, a "child may be classified as having an intellectual disability . . . when a comprehensive evaluation indicates deficits in both intellectual functioning and adaptive behavior." Ga. Comp. R. & Regs. 160-4-7-.05 app. (e).

Nor does Georgia require a beyond-a-reasonable-doubt standard in procedural areas, like limitations periods, declaratory judgments, and prescription laws. Two statute of limitations provide for certain limitations periods depending on whether a person was legally incompetent "because of intellectual disability." Ga. Code Ann. §§ 9-3-90(a) (general statute of limitations), 9-3-73(c)(1) (medical-malpractice statute of limitations). A statute providing for declaratory judgments in the trusts-and-estates context allows such judgments for the trusts or estates of people who are

"legally incompetent because of mental illness or intellectual disability," among other things. Ga. Code Ann. § 9-4-4(a). And a prescription statute tolls the prescription period so long as a person "incompetent by reason of mental illness or intellectual disability" continues to have that mental illness or intellectual disability. Ga. Code Ann. § 44-5-170. Nowhere in these laws does Georgia require intellectual disability to be proven beyond a reasonable doubt. *See Kim* v. *Metropolitan Atlanta Olympic Games Authority*, 489 S.E.2d 372, 372 (Ga. Ct. App. 1997) ("A party in a civil case meets the burden of proof by a preponderance of the evidence.").

It is even less appropriate to require proof of intellectual disability beyond a reasonable doubt when a defendant faces a death sentence than in the myriad situations described above. The beyond-a-reasonable-doubt standard is meant to reduce the risk of factual errors for a party who has "an interest of transcending value" at stake. *In re Winship*, 397 U.S. 358, 364 (1970) (quoting *Speiser* v. *Randall*, 357 U.S. 513, 525–26 (1958)). It does so by forcing the party who seeks to extinguish that important interest to meet the most exacting standard of proof known to the law. To require a capital defendant to prove intellectual disability beyond a reasonable doubt to avoid a death sentence turns this fundamental constitutional precept on its head—requiring a capital defendant to meet a standard of proof far more rigorous than that the State requires for determining intellectual disability in *any* other context. In so doing, Georgia all but ensures that it will put to death persons whom the Constitution categorically forbids executing, for it has required a level of scientific and medical certainty that will be unattainable in almost all cases. That risk is constitutionally intolerable.

CONCLUSION

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

Respectfully submitted,

DONALD B. VERRILLI, JR.
Counsel of Record
LEONARDO MANGAT
MUNGER, TOLLES & OLSON LLP
601 Massachusetts Ave. NW
Suite 500E
Washington, DC 20001
(202) 220-1100
Donald.Verrilli@mto.com

Counsel for Amici Curiae

December 27, 2021

ADDENDUM

The **Disability Rights Legal Center (DRLC)** is a non-profit 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 U.S. 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 Annenberg Center, 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.