In the Supreme Court of Georgia

Case No. S21P0078

RODNEY RENIA YOUNG,

Appellant,

vs.

THE STATE OF GEORGIA,

Appellee.

BRIEF FOR AMICI CURIAE THE ARC OF THE UNITED STATES, THE ARC OF GEORGIA, AND THE GEORGIA ADVOCACY OFFICE

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STATEMENT OF INTEREST OF AMICI CURIAE

The Arc of the United States: Founded in 1950, The Arc of the United States ("The Arc") has grown to become the nation's largest community-based organization of and for people with intellectual and developmental disabilities. The Arc's mission is to promote and protect the human rights of people with intellectual and developmental disabilities and actively support their full inclusion and participation in the community throughout their lifetimes.

The Arc is deeply invested in ensuring that people with intellectual and developmental disabilities receive the rights and protections to which they are entitled by law. Since its inception, The Arc has played a key role in legislation to establish federal disability rights laws, such as the Individuals with Disabilities Education Act ("IDEA"), the Rehabilitation Act of 1973, and the Americans with Disabilities Act ("ADA"). The Arc has also led multiple public policy efforts to establish, expand, and maintain critical federal programs.

Throughout its history, The Arc and its chapters have used litigation to advance the rights of people with intellectual and developmental disabilities. Cases brought by The Arc and its chapters in the 1970s, including *PARC v. Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971), and *Halderman v. Pennhurst*, 446 F.Supp. 1295 (E.D. Pa. 1977) (more than 28 opinions issued during extensive litigation), led to critical protections for people with intellectual and developmental disabilities in

schools and institutions, and paved the way for the IDEA and the ADA.

Since 1950, The Arc has also participated in a wide variety of amicus briefs in jurisdictions throughout the country to advance the rights of people with intellectual and developmental disabilities in all aspects of life, including community integration, fair housing, employment, education, criminal justice, parenting, self-determination, and healthcare. The Arc has also joined numerous amicus briefs before the U.S. Supreme Court including *Endrew F. ex rel. Joseph F. v. Douglas Cty. Sch. Dist. RE-1*, 137 S. Ct. 988 (2017) and *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

As relevant to Mr. Young's case, The Arc has long advocated under the Eighth Amendment to prohibit the execution of people with intellectual disability[1] ("ID") and has appeared as amicus curiae in a variety of cases involving ID and the death penalty, including *Atkins v. Virginia*, 536 U.S. 304 (2002), *Hall v. Florida*, 572 U.S. 701 (2014) and *Moore v. Texas*, 137 S. Ct. 1039 (2017) ("*Moore I*").

The Arc of Georgia: The Arc of Georgia, an affiliate of The Arc of the United States, serves Georgians with intellectual and developmental disabilities via 12 local chapters throughout the state. In 1988, together with The Arc of the United States, The Arc of Georgia played a key role in securing Georgia's decision to prohibit the

[1] *Criminal Justice System*, The Arc, https://thearc.org/position-statements/criminal-justice-system/.

execution of individuals with ID thirteen years before the U.S. Supreme Court established a constitutional exemption in *Atkins*. The Arc of Georgia has insisted that Georgia's burden of proof creates a grave risk that individuals with ID will be executed in violation of the United States Constitution. Indeed, The Arc of Georgia has been among the leaders in a coalition advocating for legislation to change Georgia's standard for *Atkins* relief from "beyond a reasonable doubt" to a constitutionally permissible burden.[2]

The Georgia Advocacy Office: The Georgia Advocacy Office ("GAO") is the designated Protection and Advocacy System for the State of Georgia. GAO's 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.

In light of their missions, The Arc, The Arc of Georgia, and GAO (collectively, "Amici") all have a strong interest in seeing Georgia return to its position as a leader with respect to safeguarding the constitutional rights of defendants with ID.

[2] *Real Communities: Intellectual Disability and the Death Penalty in Georgia*, Georgia Council on Developmental Disabilities (Jan. 8, 2016), https://gcdd.org/blogs/2865-real-communities-intellectual-disability-and-the-death-penalty-in-georgia.html.

INTRODUCTION AND SUMMARY OF ARGUMENT

The definition of intellectual disability ("ID") has three prongs.[3] The first addresses an individual's intellectual functioning, the second addresses an individual's everyday functioning, and the third addresses an individual's age at the time of disability onset. People with ID struggle significantly with intellectual functioning, in performing things like reasoning, problem-solving, and thinking abstractly,[4] as well as with day-to-day (adaptive) functioning in using conceptual, social or practical skills.[5]

[3] ID is the modern term for the condition once called mental retardation. Clinicians and professionals in the field now employ the term ID. Robert L Schalock, et al., *The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability*, 45 Intell. & Developmental Disabilities 116 (2007). This brief uses these terms in place of "mental retardation" except where directly quoting statutes or other sources. Although the latter term appears in some relevant case law and scholarly articles, it is offensive to many persons and has been replaced by more sensitive and appropriate terminology. As the U.S. Supreme Court stated in *Hall*: "Previous opinions of this Court have employed the term 'mental retardation.' This opinion uses the term 'intellectual disability' to describe the identical phenomenon." 134 S. Ct. at 1990 (*citing* Rosa's Law, 124 Stat. 2643 (changing entries in the U.S. Code from "mental retardation" to "intellectual disability")).

[4] AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 31 (11th ed. 2010) (hereinafter cited as "AAIDD, 2010"). The American Association on Intellectual and Developmental Disabilities (AAIDD) is the nation's oldest and largest organization of professionals in the field of intellectual disability. Its diagnostic manual is one of the most cited and highly regarded works on intellectual disability.

[5] AAIDD, 2010 at 44.

In other words, by definition, every individual diagnosed with ID has deficits and limitations.[6] At the same time, clinicians universally recognize that, in the lives of individuals with ID, weaknesses in functioning co-exist with relative strengths.[7] Therefore, while some individuals have more pervasive and severe challenges, others' symptoms may be less immediately recognizable to a layperson as having ID. The latter group–i.e., those who have what is sometimes called, misleadingly, "mild" ID–make up the majority of people who have ID.[8]

Regardless of their strengths or limitations, every individual diagnosed with ID is unequivocally protected by the *Atkins* decision prohibiting the execution of people with intellectual disability. *Atkins v. Virginia*, 536 U.S. 304, 318 (2002).

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[6] AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 5 (11th ed. 2010); *see also* James W. Ellis, Caroline Everington, and Ann M. Delpha, *Evaluating Intellectual Disability: Clinical Assessments in* Atkins *Cases*, 46 Hofstra L. Rev. 1305, 1329-36 (2018) (hereinafter cited as "*Evaluating ID*").

[7] As the AAIDD classification manual explains, the finding of "significant limitations in conceptual, social, or practical adaptive skills is not outweighed by the potential strengths in some adaptive skills." AAIDD, 2010, at 47. This fact has long been recognized and accepted by clinicians. *See, e.g.*, *American Association on Mental Retardation, Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992) ("Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities . . . ."); *see also* Martha E. Snell & Ruth Luckasson, et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual & Developmental Disabilities 220, 220 (2009) ("[A]ll individuals with [ID] typically demonstrate strengths in functioning along with relative limitations.").

[8] Marc J. Tassé, *Adaptative Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 117 (2009) ("[T]he vast majority of individuals with [ID] (i.e. 85%) are in this range of functioning.").

Understanding the characteristics of ID, how it manifests, the clinical tools used to diagnose it, and laypersons' false assumptions about it are critical to understanding why Georgia's extraordinary burden of proof creates a constitutionally unacceptable risk that defendants who have legitimate claims of ID will nonetheless be sentenced to death.

Georgia was the first state in the nation to establish a prohibition against executing individuals with ID thirteen years before the U.S. Supreme Court established a constitutional exemption in *Atkins*.[9] However, Georgia codified its 1988 bar on executing people with ID by grafting it into a pre-existing section of the Georgia Code: O.C.G.A. § 17-7-131.[10] That statute did not concern either intellectual disability or the penalty phase of a death penalty trial. In fact, it addressed a different topic altogether, having been written to address pleas of insanity at the guilt phase of felony criminal trials. Because Georgia's bar on executing people with ID happened to be grafted onto an insanity defense statute, the language requires that a jury find "*beyond a reasonable doubt*" both that the defendant is guilty of the crime

[9] *See* Lauren Sudeall Lucas, *An Empirical Assessment of Georgia's Beyond A Reasonable Doubt Standard to Determine Intellectual Disability in Capital Cases*, 33 Ga. St. U. L. Rev. 553, 560 (2017) (hereinafter cited as "*Empirical Assessment*"); Lauren A. Ricciardelli & Kevin M. Ayres, *The Standard of Proof of Intellectual Disability in Georgia: The Execution of Warren Lee Hill*, 27 J. Disability Pol'y Stud. 158, 158 (2016).

charged, *and* that he has ID. *See* O.C.G.A. § 17-7-131. Georgia is the only state in the nation that has imposed this unprecedented burden on those with ID.

Despite Georgia's early leadership on this issue, in the last 30 years, not a single capital defendant in Georgia has successfully obtained protection from the death penalty as a result of ID in a case of intentional murder.[11] Conversely, between 2002 and 2013, the overall success rate for individuals making *Atkins* claims throughout the country was fifty-five percent (55%), varying over time from 26% to 63%, depending on the time period and the inclusion of unpublished cases.[12] As set forth below, Georgia's onerous burden of proof of intellectual disability "beyond a reasonable doubt" is incompatible with the clinical diagnostic criteria and encourages jurors to act on false assumptions and stereotypes about people with ID, resulting in an unconstitutional risk that people with intellectual disability will be executed.

Since this Court last examined Georgia's statute in 2011, the U.S. Supreme Court decided three cases in which it clearly mandated the use of clinical science, not stereotypes and false assumptions, in evaluating *Atkins* claims. *Hall v. Florida*

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[11] *See Empirical Assessment* at 582, 604.

[12] John H. Blume, Sheri Lynn Johnson, Paul Marcus, and Emily Paavola, *A Tale of Two (and Possibly Three) Atkins: Intellectual Disability and Capital Punishment Twelve Years After the Supreme Court's Creation of a Categorical Bar*, 23 William & Mary Bill of Rights J. 393, 397-98 (2014).

was issued in 2014, and established that the clinical science around IQ testing must inform states' procedures for *Atkins* enforcement.[13] Then in 2017, the Court decided *Moore v. Texas* ("*Moore I*"), essentially barring the use of stereotypes, and mandating that states use clinical science to define functional deficits in ID. [14] *Moore I* was almost immediately followed by *Moore v. Texas* ("*Moore II*") in 2019, only two terms later, when the Court found that Texas' changes to its *Atkins* framework failed to comply with the mandate of *Moore I*.[15] In sum, the U.S. Supreme Court has mandated that, post-*Atkins*, states cannot ignore clinical science or impose procedures that "create[] an unacceptable risk" that individuals with ID will be executed.[16]

Georgia's statute creates precisely such a risk, because it fails to protect the constitutional rights of "the entire category of [intellectually disabled] offenders." *Moore I*, 137 S. Ct. at 1052 (quotation omitted). The beyond a reasonable doubt standard mandated by the statute invites jurors to reject legitimate claims based on a 'lingering doubt' that the defendant has intellectual disability because he does not meet their false assumptions and stereotypes about people with ID. This Court should re-examine Georgia's burden of proof for a claim of ID in *Atkins* cases, and

[13] *Hall*, 572 U.S. 701.
[14] *Moore I*, 137 S. Ct. 1039.
[15] *Moore II*, 139 S. Ct. 666.
[16] *Hall*, 572 U.S. at 704.

take action to protect the constitutional rights of Mr. Young and *all* capital defendants in Georgia who have ID.

ARGUMENT

I. GEORGIA'S BEYOND A REASONABLE DOUBT STANDARD IS INCONSISTENT WITH CLINICAL STANDARDS.

A. Experienced Clinicians Diagnose Intellectual Disability Analyzing Three Prongs Using Clinical Judgment And Experience

The Georgia statute defines ID as "significantly subaverage general intellectual functioning resulting in or associated with impairments in adaptive behavior which manifested during the developmental period." O.C.G.A. § 17-7-131(a)(3). This statutory definition aligns with the clinical consensus that ID is comprised of three prongs: (1) significant impairments in intellectual functioning, (usually measured by IQ testing); (2) adaptive behavior deficits in conceptual, social, and/or practical skills; and (3) the onset of the disability before age 18.[17] The U.S. Supreme Court has repeatedly held that this definition is the minimum constitutional requirement for evaluating *Atkins* claims. *Atkins*, 536 U.S. at 317; *Hall*, 572 U.S. at 709-10; *Moore I*, 137 S. Ct. at 1044.

Evaluations of ID in *Atkins* cases require the expertise of clinicians trained

[17] *See, e.g.*, AAIDD, 2010 at 5; *accord* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 33 (5th ed. 2013) (hereinafter cited as "APA, DSM-5").

and experienced in conducting ID diagnoses. Proper evaluation requires the careful consideration of information gathered from numerous sources relevant to each of the three diagnostic prongs, combined with knowledge, experience, and a clinical understanding of the nature of ID and how it manifests. Put another way, a clinician's experience and judgment, rooted in an understanding of the diagnostic process and made after considering extensive data, are critical to a proper diagnosis of ID.[18]

Critically, from a clinical perspective, it is the nature and severity of the *deficits*–i.e., the things that someone cannot do–that determine a diagnosis.[19] However, most people who have ID (i.e., those with so-called "mild" ID) have challenges that are perhaps not immediately apparent to a layperson.[20] For example, as in the case of Mr. Young, a person with "mild" ID may be able to take the bus

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[18] *See, e.g.*, AAIDD, *User's Guide: To Accompany the 11th Edition of Intellectual Disability: Definition, Classification and Systems of Supports* 9 (2012) ("Clinical judgment is a special type of judgment rooted in a high level of clinical expertise and experience; it emerges directly from extensive data."); 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) at 198 (explaining "the clinical experience and interpretive judgment of the diagnostician are integral to the ultimate diagnosis"); *Evaluating ID* at 1416-17.

[19] *Evaluating ID* at 1393 ("[T]he diagnostic evaluation of adaptive behavior focuses on the individual's weaknesses, and does not "balance them against those things that the individual actually can do.").

[20] *See* AAIDD, *User's Guide: Mental Retardation Definition, Classification and Systems of Supports* 16 (10th ed. 2007) (explaining that individuals with ID who have IQs at the higher range of the diagnosis "while meeting the three criteria of [ID], manifest subtle limitations that are frequently difficult to detect ….").

independently, but not understand that a bus is on a timetable and will leave without them if they are not on time.[21] They may live in an apartment on their own, but need help every month to understand that the rent needs to be paid and/or how to pay it.

Laypeople often do not realize that the existence of "strengths" is typical in people with ID.[22] As a result, despite the significant challenges those with "mild" ID face in intellectual functioning and adaptive behaviors, they are unlikely to match the stereotypical image of people with ID held by many laypeople, including jurors. However, individuals with ID who have higher IQs – i.e., those with so-called mild ID – actually constitute 80-90% of all those with ID. *See, e.g.*, Snell, *Characteristics* at 220. These individuals make up the vast proportion of individuals with ID in the criminal justice system. *See* Gilbert S. Macvaugh & Mark D. Cunningham, *Atkins v. Virginia: Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & Law 131, 142 (2009) (stating that "virtually all" capital offenders with ID "are within the mild category"); Daniel J. Reschly, *Documenting the Developmental Origins of Mild Mental Retardation*, 16 Applied Neuropsychology 124, 125 (2009) (explaining that death penalty appeals involving ID claims "virtually always" involve mild ID).

As set forth in more detail below, jurors' misperceptions and

[21] *See* Appellant's Brief at 183-84.
[22] *See* Snell, *Characteristics* at 221.

misunderstanding regarding how ID manifests can have devastating implications for those with "mild" ID in a capital case.

1. Intellectual Functioning Is Usually Measured with IQ Testing, Which Is Inherently Imprecise.

The first prong of the definition requires that an individual have "significantly subaverage general intellectual functioning[.]" O.C.G.A. § 17-7-131(a)(2). This is usually measured by administering a valid intelligence quotient ("IQ") test. Generally speaking, IQ tests are designed to measure what an individual has learned over time, thereby revealing the subject's ability or capacity to learn and process information.[23]

The assessment of intelligence evaluates a person's mental abilities as compared to their peers. An IQ score measures an individual's performance on a battery of standardized tests in comparison to a group of people who reflect the demographic composition of the United States in terms of gender, race, and age.[24] An IQ score reflecting average intelligence is 100, with one standard deviation being about 15 points in either direction.[25] This means that, statistically, 68.8% of test takers receive IQ scores between 85 and 115. To meet the definition of ID, a person's

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[23] *See* Alan S. Kaufman & Elizabeth O. Lichtenberger, *Assessing Adolescent and Adult Intelligence*, 23 (3d ed. 2006); Anne Anastasi & Susana Urbina, *Psychological Testing* 296 (7th ed. 1997).
[24] *See Evaluating ID* at 1347-48.
[25] *See id.* at 1348.

IQ score must fall at least *two* standard deviations below the mean of the test (i.e., 100), which in most cases is a score no higher than approximately 75.[26] Only about 2-3% of the population have IQ scores that are this low.[27]

There are a variety of tests designed to measure intelligence, but two of the most highly-regarded tests used today are the Wechsler Adult Intelligence Test – 4th Edition ("WAIS-IV") and the Stanford Binet – Fifth Edition ("SB-5"). The WAIS-IV and the SB-5 are a series of 10 subtests that measure multiple dimensions of intelligence based on contemporary research and an increasing sophistication in psychological measurement.[28] Both test batteries are designed to delineate the cognitive strengths and weaknesses of all individuals, including those with ID.

Administering and interpreting IQ testing, which has been utilized and refined for more than 100 years, requires the professional judgment of trained and licensed psychologists or other qualified clinicians.[29] IQ tests, like many psychological

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[26] *See id.*

[27] *See, e.g.*, Marc J. Tassé Robert L. Schalock, Giulia Balboni, Hank Bersani, Jr., Sharon A. Borthwick-Duffy, Scott Spreat, David Thissen, Keith F. Widman & Dalun Zhang, *The Construct of Adaptive Behavior: Its Conceptualization, Measurement, and Use in the Field of Intellectual Disability*, 117 Am. J. on Intellectual & Developmental Disabilities 291, 298 (2012); *see generally* Muriel D. Lezak, et al., *Neuropsychological Assessment* (5th ed. 2012).

[28] *See Evaluating ID* at 1348-57.

[29] AAIDD, 2010 at 40 ("As discussed in reference to the operational definition of significant limitations in intellectual functioning, the intent of using approximately two standard deviations below the mean is to reflect the role of clinical judgment in weighing the factors that contribute to the validity and precision of a diagnostic

instruments, are inherently imprecise because they must be read "not as a single fixed number but as a range." *See, e.g.*, *Hall*, 572 U.S. at 712 (citations omitted). To address this concern, psychologists have developed a specific tool called the "standard error of measurement" or SEM.[30] The SEM is essentially a quantification of how likely it is that the score of a particular test administered on a particular day is a truly accurate measure of the individual's intellectual ability.[31] "The SEM reflects the reality that an individual's intellectual functioning cannot be reduced to a single numerical score." *Hall*, 572 U.S. at 713. This can confuse jurors–and result in unconstitutional outcomes for defendants with ID–because jurors often lack sufficient understanding of these statistical concepts. As explained in the leading treatise on neuropsychological testing, understanding IQ scores is complicated by

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decision."); APA, DSM-5 at 337 ("Clinical training and judgment are required to interpret test results and assess intellectual performance."). *See generally* Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* (2d ed. 2014).

[30] Edward J. Slawski, *Error of Measurement*, in 1 *Encyclopedia of Human Intelligence* 395 (Robert J. Sternberg ed., 1994). Psychologists do not use the word "error" in the way it is employed in ordinary language, i.e., as a synonym for "mistake." The SEM is not a "mistake" in the sense that mistakes are avoidable, nor is it an "error" that can be "fixed." Rather, "error" is a term of art that describes the inevitable imprecision of any psychometric measurement. *See* Earl Hunt, *Human Intelligence* 313 (2011).

[31] Domenic V. Cicchetti, *Guidelines, Criteria, and Rules of Thumb for Evaluating Normed and Standardized Assessment Instruments in Psychology*, 6 Psychological Assessment 284, 285 (1994) ("The standard error of measurement defines that amount of test-retest variability that is expected to occur on the basis of the inherent imprecision of the assessment instrument itself.").

the "natural assumption that if one measurement is larger than another, there is a difference in the quantity of whatever is being measured. . . . [T]wo different numbers need not stand for different quantities but may be chance variations in the measurement of the same quantity."[32]

Additionally, IQ test results can be affected by the way in which a test is administered—e.g., how much time is allotted for questions or the rapport between the test taker and administrator. Even seemingly small mistakes in administering and/or scoring IQ tests may skew the results. Clinicians also acknowledge that IQ scores resulting from some less robust tests, such as group tests and screening tests, may be unreliable, and overstate intelligence, particularly in people who may have ID.[33]

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[32] Lezak at 200-01.

[33] *See, e.g.*, John R. Slate, et al., *Practitioners' Administration and Scoring of the WISC-R: Evidence That We Do Err*, 30 J. School Psychology 77, 81 (1992); Caroline Everington, *Challenges of Conveying Intellectual Disabilities to Judge and Jury*, 23 Wm. & Mary Bill of Rights J. 467, 474 (2014) ("A commonly observed error is the reliance on screening or group-administered intelligence tests that do not provide accurate measures of IQ. . . . Group-administered paper and pencil tests, such as the *Beta III*, used in correctional settings, are also inappropriate for diagnosis as they do not yield accurate scores. In the case of group-administered tests, there is the additional risk that the individual received additional help or copied the responses of others."); AAIDD, 2010 at 41 ("For evaluating whether or not a person meets the significant limitations in intellectual functioning criterion for a diagnosis of ID, one should employ an *individually administered*, standardized instrument that yields a measure of general intellectual functioning.") (emphasis added).

Prosecutors can exploit these inevitable imprecisions, as well as jurors' misconceptions about IQ scores, by suggesting that a score which, considering these imprecisions, is within the range of ID, should raise a "doubt" in jurors' minds regarding a defendant's claim. For example, a hypothetical defendant with a reported IQ score over 75 may nonetheless have significantly subaverage intellectual functioning (as required in prong 1), because that score may result from administration or scoring mistakes, the use of a short, group, or other less-reliable tests, other testing problems, or from simply the necessary imprecision of this type of testing.[34] As Justice Kennedy wrote for the Court in *Hall v. Florida*, "[ID] is a condition, not a number." 572 U.S. 701, 723 (2014).

2. The Assessment of Adaptive Functioning Involves Clinical Expertise and a Careful Analysis of an Individual's Personal History.

The second prong of the analysis concerns an individual's adaptive functioning—i.e., the individual's problems with respect to functioning in everyday life.[35] The assessment of adaptive functioning requires a careful analysis of all the available information about adaptive deficits by clinicians with expertise in diagnosing ID.[36]

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[34] *See Evaluating ID* at 1347-66.
[35] *Evaluating ID* at 1329.
[36] *See, e.g.*, Reschly, *Developmental Origins* at 132 (2009) ("No single information element or source is ever sufficient to diagnose MMR [mild mental retardation]

Clinicians assessing adaptive behavior deficits are required to make a "wide[]-ranging inquiry" as to whether "there are sufficient limitations in [an] individual's functioning under ordinary circumstances."[37] The goal is to assess an individual's "actual everyday functioning."[38] Therefore, clinicians must focus their adaptive behavior inquiry on "how an individual performed (or failed to perform) tasks in general society."[39]

As a result, evaluating this second prong of the definition of ID typically requires extensive information-gathering from those who knew the individual *prior* to incarceration. *See, e.g.*, *Moore I*, 137 S. Ct. at 1050 ("Clinicians, however, caution against reliance on adaptive strengths developed in a controlled setting, as a prison surely is.") (internal quotation omitted); *Moore II*, 139 S. Ct. at 670-71.[40] This makes

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developmentally or during the adult years. Even a very low score on a single measure of general intellectual functioning is never sufficient. All valid MMR diagnoses require consideration of a broad variety of information. Four types of information should be considered: (a) tests given directly to the individual, (b) observations of the individual in relevant settings, (c) records from all available sources, and (d) interviews with relevant persons.").

[37] *Evaluating ID* at 1332 (emphasis omitted).

[38] *Id.* at 1333 (emphasis omitted).

[39] *Id.* at 1334; *see also Moore I*, 137 S. Ct. at 1050.

[40] Caroline Everington, et al., *Challenges in the Assessment of Adaptive Behavior of People Who Are Incarcerated*, *in* The Death Penalty and Intellectual Disability 201, 202 (Edward A. Polloway ed., 2015) ("[A] satisfactory assessment of AB is not possible in a prison context because the individual has no opportunities to demonstrate the presence or absence of adaptive skills typical in day-to-day life. Inmates do not cook, choose clothing, or make independent choices about their day-to-day existence. By design, correctional settings remove virtually all personal

assessing adaptive functioning complex, depending on the availability of accurate witnesses to a defendant's pre-incarceration behavior, further accentuating the inappropriateness of a beyond a reasonable doubt burden of proof.

When evidence of a diagnosis in school is available, as it is in Mr. Young's case, it is extraordinarily valuable in determining an ID diagnosis.[41] Schools are the most frequent source of an initial diagnosis of ID, because they are often the first place where people outside the family have the opportunity to notice a child's learning and daily living challenges.[42] For a variety of reasons, schools are often under-inclusive, not over-inclusive, in determining who is eligible for special education services.[43] In the instant case, the school records that exist have been bolstered by testimony from teachers, social workers, and a special education department head, that Mr. Young consistently demonstrated deficits which, among

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control from the individual, and, as such, practical behaviors pertinent to the diagnosis cannot be demonstrated."); Macvaugh, *Forensic Practice* at 161 ("Institutional adaptation should generally not be regarded as dispositive of adaptive functioning in the open community. In such situations, forensic examiners should clearly state the limitations of retrospective assessments of adaptive functioning.").

[41] *See, e.g.*, Appellant's Brief at 170, 175-77, 179-89.

[42] *See* Snell at 221; *Evaluating ID* at 1381-82; Matthew H. Scullin, *Large State-Level Fluctuations in Mental Retardation Classifications Related to Introduction of Renormed Intelligence Test*, 111 Am. J. Mental Retardation 322, 324 (2006); Reschly, *Developmental Origins* at 126-30.

[43] *Evaluating ID* at 1338 n.140.

other things, necessitated academic accommodations.[44] That Mr. Young presented such strong, school-based evidence of his disability and was still unable to persuade jurors of his ID diagnosis is yet another illustration of the impossible-to-meet burden that the beyond a reasonable doubt standard imposes on capital defendants who present *Atkins* claims.

Where a defendant's school records are incomplete, non-existent, or unavailable, and there are no reliable witnesses to the defendant's educational placement; where a defendant attended a school that did not even maintain special education programs (before they were mandated by IDEA); where parents and relatives are unavailable to describe core behavioral abilities; where steady employment records are missing and witnesses unavailable, etc., it may be even more difficult to present to a jury a comprehensive portrait of a defendant's adaptive behavior deficits that leaves them with no "lingering doubt." Moreover, the risk factors for ID include, among other things, poverty, trauma, and abuse, AAIDD, 2010 at 60, conditions that, due to stigma, are often difficult to document. The

[44] Indeed, the record reveals that special care was taken by the head of the special education department of the high school Mr. Young attended to make sure that he actually qualified for, and needed, special education. *See, e.g.*, Appellant's Brief at 175-76 (explaining that Wayne Hendricks knew Mr. Young and took care that "all of his students in special education belonged there"). As a result, the school's diagnosis and placement of him should be considered very persuasive by an experienced clinician.

beyond a reasonable doubt standard, acting in concert with the practical problems inherent in gathering the records and information under these circumstances, creates a constitutionally unacceptable risk of executing people with ID.

Furthermore, as noted above properly assessing this prong requires consciously focusing *solely* on an individual's *deficits*.[45] *Moore I*, 137 S. Ct. at 1043 (explaining "the medical community focuses the adaptive-functioning inquiry on adaptive *deficits*") (emphasis in original). In other words, in the diagnosis of ID clinicians focus only on what the individual *cannot* do—an approach which may seem "counterintuitive to many people," including jurors.[46] *See also Moore II*, 139 S. Ct. at 670-71 (criticizing the Texas Court of Criminal Appeals for improperly "again rel[ying] less upon the adaptive *deficits* to which the trial court had referred than upon Moore's apparent adaptive *strengths*" in contravention of clinical science) (emphasis in original). Individuals with ID often can, with assistance, learn to engage in routine aspects of daily life, including securing and maintaining employment, living in an apartment, participating in personal relationships, using public transportation, and even driving a car, doing basic housecleaning, writing checks, and the like. Indeed, clinical literature is abundantly clear that many of the people who have been properly diagnosed with ID can perform one or more of these

[45] *Evaluating ID* at 1335-36.
[46] *Id*.

tasks.[47]

As clinicians have explained:

> Whereas many of these individuals 'living "independently" predictably will need support in relation to specific issues' (*e.g.*, housing employment, transportation, health services [citation]), some individuals in this group 'may develop homes and home lives independent of a formal agency support once the time comes for them to live separately from their families' [citation]. These documented outcomes contrast sharply with the incorrect stereotypes that these individuals cannot have friends, jobs, spouses, or children or be good citizens.

See Snell, *Characteristics* at 221.

More importantly, these and other similar types of "strengths may confound a layperson or a professional with limited clinical experience with individuals who have mild [ID]."[48] Jurors may believe, incorrectly, that strengths displayed by a defendant create a "reasonable doubt" as to the credibility of an ID diagnosis—even though purported strengths are clinically irrelevant in arriving at a diagnosis.

The danger of jurors being misled or confused about the clinical requirements of the adaptive behavior analysis, when combined with the pervasiveness of false

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[47] *See, e.g.*, Schalock, *Clinical Judgment* at 38–39; Roger J. Stancliffe & K. Charlie Lakin, *Independent Living*, *in* Handbook of Developmental Disabilities 429, 430 (Samuel L. Odom et al. eds., 2007); Snell, *Characteristics* at 221. For a detailed description of some of the tasks of daily living that people with ID can learn to do, see *Evaluating ID* at 1403-1404 & nn.380-83 and sources therein.

[48] Marc J. Tassé, *Adaptative Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 121 (2009).

assumptions held by the general public regarding ID, discussed below, further renders a beyond a reasonable doubt standard unacceptably likely to result in the unconstitutional execution of those with ID.

3. Onset During the Developmental Period Requires Retrospective Analysis and the Informed Interpretation of Records.

Finally, clinicians have to determine whether the identified deficits originated during an individual's developmental years.[49] This necessarily means that a clinician must engage in a retrospective assessment, gathering the available information from a variety of records and from individuals who knew the defendant in his developmental years. Depending on the age of the defendant at the time of incarceration, this can involve looking back several decades. Similar to the second prong, the complexities presented by historical fact-gathering make a beyond a reasonable doubt standard virtually impossible to meet and constitutionally unacceptable.

In sum, the nature of the sort of evidence gathered in an evaluation for intellectual disability is incompatible with this onerous standard, one that leaves no

[49] *See, e.g.*, APA, DSM-5 at 33 ("[ID] . . . is a disability with onset during the developmental period . . . ."). Critically, there is no requirement "that there have been IQ tests or formal assessments of adaptive deficits while the individual was a child." *Evaluating ID* at 1338.

room for the inherent variability of evidence relevant to the diagnostic process, even in legitimate claims of intellectual disability. Requiring an individual to establish all three prongs of an ID diagnosis beyond a reasonable doubt, as Georgia's statute currently requires, creates a constitutionally unacceptable risk that an individual with ID will be executed.

B. Pervasive, Stereotypes and False Assumptions Regarding Intellectual Disability Further Increase the Risk that Individuals with Intellectual Disability will be Executed Contrary to Constitutional Protections

The task of explaining a diagnosis of ID, particularly mild ID, to juries is complicated by the fact that jurors often hold any number of incorrect stereotypes about how people with ID look and behave. *See*, *e.g.*, *Moore I*, 137 S. Ct. at 1051-52 (explaining that "the medical profession has endeavored to counter lay stereotypes of the intellectually disabled" and that such "stereotypes, much more than medical and clinical appraisals, should spark skepticism"). One of the most pervasive and harmful beliefs is that all individuals with ID can be identified by readily-observable physical traits and behaviors and will clearly "present" as people with ID. This belief is contradicted by clinicians, who have made it clear:

> In fact, we cannot 'see' the offender with ID any more obviously than we can 'see' the offender without ID. There are no labels on their backs, and there are often no obvious signs that they are impaired enough to warrant attention. That said, underneath what appear to be typical offenders lie true differences in cognitive abilities[.]

Karen L. Salekin, et al., *Offenders with Intellectual Disability: Characteristics, Prevalence, and Issues in Forensic Assessment*, 3 J. Mental Health Res. In Intell. Disabilities 97, 110 (2010). Nevertheless, many laypeople, even those with the best of intentions, incorrectly believe that they can "tell" either by observing or by interacting with an individual whether that person has ID.[50] Contrary to many laypersons' belief, "[m]ost of these individuals are physically indistinguishable from the general population because no specific physical features are associated with ID at higher IQs."[51]

In addition, and also contrary to widely held popular beliefs, there are no "definite behavioral features [] specifically associated with [ID] with higher IQs."[52] That said, individuals with ID frequently, "tend to do what others want in an effort to be accepted or liked by them."[53] A "cardinal feature" of ID is gullibility, which can result in individuals with ID being "talked into doing things without understanding the potential consequences."[54] They are also often naïve and "overly trusting of others" and this "naiveté" or "suggestibility" combined with "gullibility

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[50] *See generally* Andrea D. Lyon, *But He Doesn't* Look *Retarded: Capital Jury Selection for the Mentally Retarded Client Not Excluded After* Atkins v. Virginia, 57 DePaul L. Rev. 701, 713-17, App'x at 718-19 (2008).
[51] Snell, *Characteristics* at 220.
[52] *Id.*
[53] *Id.* at 226.
[54] *Id.*

may increase [an individual with ID's] risk of making poor decisions."[55]

Further complicating things, the clinical literature has documented for decades that individuals with ID, especially those with higher IQs, frequently seek to mask their limitations and weaknesses from others.[56] This is a result of the intense stigma that can be associated with being perceived or "labeled" as a person with ID.[57] This "masking" behavior can have the effect of disguising substantial limitations in understanding and functioning and may mislead jurors, who only need a "reasonable doubt" to reject an *Atkins* claim.

Misguided reliance on lay (mis)perceptions and stereotypes, rather than clinical science, in diagnosing ID in *Atkins* cases was condemned in *Moore I* and *Moore II*. *See Moore I*, 137 S. Ct. at 1051; *Moore II*, 139 S. Ct. at 679. For all of these reasons, requiring an individual to establish ID beyond a reasonable doubt creates a dangerously high and constitutionally unacceptable risk that an individual with ID will be executed.

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[55] *Id.*

[56] *See, e.g.*, Robert B. Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (1967); Snell, *Characteristics* at 226 ("Individuals with [ID] may go to great lengths to hide their limitations, consuming significant effort to attempt to appear as their often-mistaken image of competent.").

[57] *See Evaluating ID* at 1368.

II. SINCE THIS COURT LAST EXAMINED THE CONSTITUTIONALITY OF GEORGIA'S BURDEN OF PROOF, THE U.S. SUPREME COURT HAS PROVIDED CLEAR GUIDANCE TO STATES MANDATING THE USE OF CLINICAL SCIENCE FOR THE DETERMINATION OF INTELLECTUAL DISABILITY IN *ATKINS* CASES.

When the United States Supreme Court held that the Eighth Amendment bars the execution of people with ID, it did so not only based on the consensus of the legislatures of 18 states (including Georgia) that executing people with ID is intolerable, but also because it recognized:

> [B]y definition [people with ID] have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others. . . . [T]hey often act on impulse rather than pursuant to a premeditated plan, and [] in group settings they are followers rather than leaders. Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability.

Atkins, 536 U.S. at 317-18.

After *Atkins* was decided, this Court (over vigorous dissent) has twice upheld Georgia's beyond a reasonable doubt burden on defendants as constitutional in *Head v. Hill*, 277 Ga. 255, 260-63 (2003), and in *Stripling v. State*, 289 Ga. 370, 371 (2011). However, since this Court last considered the issue in *Stripling*, the U.S. Supreme Court decided *Hall v. Florida*, 572 U.S. 701 (2014), *Moore v. Texas*, 137 S. Ct. 1039 (2017) ("*Moore I*"), and *Moore v. Texas*, 139 S. Ct. 666 (2019) ("*Moore*

II"). These recent decisions affirm and amplify the Supreme Court's reasoning in *Atkins*, that the same deficits that warrant a clinical diagnosis of ID make the death penalty a disproportionate punishment for offenders who have that diagnosis.

Read together, *Hall*, *Moore I*, and *Moore II* "emphasize that the Eighth Amendment requires adhering to the contemporary clinical understanding of [ID] that is reflected in the clinical literature and in the judgments by the professional associations of those who study and work in the field of [ID]." *Evaluating ID* at 1316; *Moore II*, 139 S. Ct. at 670-71 (reversing the Texas court's finding that Mr. Moore did not have ID after chastising it for repeatedly failing to adhere to clinical science). Policies or procedures that fail to adhere to clinical understandings of ID "*create*[] *an unacceptable risk* that persons with ID will be executed" and are therefore unconstitutional. *Hall*, 572 U.S. at 704 (emphasis added); *Moore I*, 137 S. Ct. at 1044 (same); *see also Moore II*, 139 S. Ct. at 670 (explaining that the Texas courts' previous manner of adjudicating ID "had no grounding in prevailing medical practice" and improperly "invited 'lay perceptions of [ID]' and 'lay stereotypes' to guide assessment of [ID]" which "creat[ed] an unacceptable risk that persons with [ID] [would] be executed") (internal citations omitted). Requiring that every juror be convinced of the defendant's disability at the highest possible evidentiary standard creates the same sort of "unacceptable risk" that the Supreme Court has rejected in its recent explanations of *Atkins*. That not one capital defendant in

Georgia has successfully obtained protection from the death penalty as a result of ID in a case of intentional murder in the last thirty years further illustrates the unattainability of this standard. [58]

Ultimately, the clinical science required for a valid diagnosis of ID, as discussed above, and the U.S. Supreme Court's rulings in *Hall*, *Moore I*, and *Moore II*, lead inevitably to the conclusion that the beyond a reasonable doubt burden of proof improperly "invite[s] 'lay perceptions of [ID]' and 'lay stereotypes' to guide assessment of [ID]" and thereby creates an "unacceptable risk" that individuals with ID will be executed in Georgia in contravention of *Atkins* and its progeny. *Moore II*, 139 S. Ct. at 669 (citing *Moore I*, 137 S. Ct. at 1051).

CONCLUSION

For all of the reasons set forth above, Georgia's "beyond a reasonable doubt" burden of proof deprives people with ID, including Mr. Young, from obtaining the federal constitutional protection established in *Atkins*, and upon which the U.S. Supreme Court elaborated in *Hall*, *Moore I*, and *Moore II*. This Court must act to eliminate this constitutionally unacceptable risk and permit capital defendants in Georgia to "have a *fair opportunity* to show that the Constitution prohibits their execution." *Hall*, 572 U.S. at 724 (emphasis added). This Court should therefore

[58] *See Empirical Assessment* at 582, 604.

reject the beyond a reasonable doubt burden of proof for ID claims in *Atkins* cases as unconstitutional.

Respectfully submitted, this 5th day of October, 2020.

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