Case No. 20-99012

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ROBERT YBARRA, JR.,

Petitioner / Appellant,

vs.

WILLIAM GITTERE, ET. AL.,

Respondents / Appellees.

Appeal from the United States District Court
for the District of Nevada
D.C. No. 3:00-cv-00233-GMN-VPC

BRIEF OF *AMICI CURIAE* AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, THE ARC, AND THE COELHO CENTER IN SUPPORT OF PETITIONER-APPELLANT'S PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC

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STATEMENTS OF *AMICI CURIAE*[1]

THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ("AAIDD") founded in 1876, is the nation's oldest and largest organization of professionals in the field of intellectual disability (ID). Primarily focused on clinical, psychological, scientific, educational, and habilitative issues, the Association also has a longstanding interest in legal issues that affect the lives of people with ID. AAIDD has formulated the most widely accepted clinical definition of intellectual disability. Both as the formulator of the clinical definition of intellectual disability, and as an interdisciplinary membership organization concerned with maintaining appropriate professional standards in the diagnosis of intellectual disability, AAIDD and its members have a strong interest in the manner in which *Atkins* claims are evaluated by courts.

THE ARC OF THE UNITED STATES ("The Arc"), founded in 1950, is the

[1] Pursuant to Rule 29(a)(4)(E) of the Federal Rules of Appellate Procedure, counsel for *Amici* state that no counsel for a party authored this Brief in whole or in part or made a monetary contribution to the preparation and submission of this Brief, and no person other than *Amici*, their members, or counsel made such a contribution. All parties consented to the filing of this Brief.

Pursuant to Rule 29(a)(4)(A) of the Federal Rules of Appellate Procedure, counsel for *Amici* state that no ***amicus curiae*** has a parent or public corporation holding more than 10% of its stock.

nation's largest community-based organization of and for people with intellectual and developmental disabilities, with over 600 state and local chapters across the country. The Arc has a vital interest in ensuring that all individuals with intellectual and developmental disabilities receive the protections and supports to which they are entitled by law, and that courts and administrative agencies employ commonly accepted scientific principles for the diagnosis of intellectual and developmental disabilities.

THE COELHO CENTER FOR DISABILITY LAW, POLICY AND INNOVATION ("Coelho Center") collaborates with the disability community to cultivate leadership and advocate innovative approaches to advance the lives of people with disabilities. The Coelho Center envisions a world in which people with disabilities belong and are valued, and their rights are upheld. It was founded in 2018 by former Congressman Anthony "Tony" Coelho, original sponsor of the Americans with Disabilities Act.

ARGUMENT

I. Introduction

Intellectual disability (ID) has been part of the human condition throughout history. *See The Story of Intellectual Disability* 19, (Michael L. Wehmeyer, ed., 2013). The disability is defined by significant difficulties with both intellectual and adaptive functioning, that manifest during the developmental period. AAIDD, *Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports* 13 (12th ed. 2021) [hereinafter *AAIDD Diagnostic Manual 12th ed.*]; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 37 (5th ed., text rev. 2022) [hereinafter *DSM-5-TR*]. ID is a life-long condition, and every person with ID struggles with at least some tasks most people can perform with ease. *See DSM-5-TR* at 39-41, 43.

Over the past 100 years, clinicians have methodically investigated and studied this condition and have developed a substantial body of knowledge regarding ID and its diagnosis. *See, e.g.*, *AAIDD Diagnostic Manual 12th ed.*; *APA* [American Psychological Association] *Handbook of Intellectual and Developmental Disabilities* (Laraine Masters Glidden et al. eds., 2021); DSM-5-TR at 37-46; *see also* Alfred Binet & Th. Simon, *The Intelligence of the Feeble-Minded* (1916); A. F. Tredgold, *Mental Deficiency* (1908).

The clinical diagnosis of ID is a complex process. *See* Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 117 (2009). There is a significant risk of error in diagnosing ID if clinical standards are not followed. *See AAIDD Diagnostic Manual 12th ed.* at 38-44 (discussing best practices and requirements for a "precise and valid" diagnosis, and avoidance of false results).

Relying on stereotypes or lay assumptions about what a person with ID 'must' look like, or what people with ID 'cannot' do, rather than applying clinical standards for assessment and diagnosis may result in an unreasonable (and invalid) interpretation of the diagnostic facts in an *Atkins* evaluation. *See, e.g.*, *Brumfield v. Cain*, 576 U.S. 305, 312-320 (2015) (finding an unreasonable interpretation of the facts where a state court abandoned clinical standards in determining that an individual was ineligible for an *Atkins* adjudication). In this context, a clinically invalid assessment risks execution of an individual with ID, a clear Constitutional violation. *See Atkins v. Virginia*, 536 U.S. 304, 321 (2002) (execution of an individual with ID is prohibited by the Eighth Amendment).

This case presents several diagnostic issues requiring the application of clinical standards. Although long-settled in clinical practice, these issues may be challenging for courts (and even for clinicians unfamiliar with ID). Courts must

resolve such questions using clinical standards in order to come to a legally 'reasonable determination of the facts' regarding the presence or absence of ID. *See, e.g.*, *Brumfield*, 576 U.S. at 312-320.

Some familiarity with the definition of ID and the manifestation of this disability may assist the Court in analyzing these diagnostic issues.

II. The Clinical Definition and Some Characteristics of Intellectual Disability.

A. Defining Intellectual Disability.

The definition of intellectual disability has three prongs:

Prong 1: "[S]ignificant subaverage general intellectual functioning" and;

Prong 2: "deficits in adaptive behavior," both of which;

Prong 3: "manifested during the developmental period."

Nev. Rev. Stat. Ann. § 174.098(7) (West 2013).

B. Some Characteristics of Intellectual Disability.

To better understand an individual's functioning and provide necessary supports and interventions, clinicians sometimes employ categories organized by the magnitude of the disability using the terms "mild," "moderate," "severe," and "profound." *AAIDD Diagnostic Manual 12th ed.* at 53; *DSM-5-TR* at 39-41. Despite their apparent familiarity, these are clinical terms of art that can be somewhat misleading to courts and observers.

1. Moderate, Severe, and Profound ID.

The "moderate," "severe," and "profound" categories encompass people whose disability is usually immediately apparent even to lay observers, often due to atypical facial features or other physical differences. *See* Gilbert S. Macvaugh III & Mark D. Cunningham, Atkins v. Virginia: *Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 142 (2009) [hereinafter *Atkins Forensic Recommendations*]. Individuals in these groups often require intensive support, and people with severe or profound ID usually need assistance with basic communication, feeding, dressing, bathing, and toileting. DSM-5-TR at 40-41. Although they are usually easy to identify, people in these categories are relatively rare; they represent only about 15 percent of the people who have ID. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 43-44 (4th ed., text rev. 2000). Their support needs are intense, and they are seldom if ever subject to criminal prosecution. *See Atkins Forensic Recommendations* at 142.

2. Most Individuals with Intellectual Disability Have "Mild" ID.

People with so-called "mild" ID constitute the vast majority (approximately 80 to 90 percent) of the population of people with ID. Martha E. Snell and Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability*

Who Have Higher IQs, 47 Intellectual and Developmental Disabilities 220, 220 (2009). The term "mild" is often misunderstood: this level of disability is "mild" *only* in comparison to the moderate, severe, and profound forms of ID; it is not mild in comparison with the general population. Because these individuals usually lack obvious physical indicators of a disability and, as discussed below, may have some verbal and interpersonal strengths as well as some other abilities, they tend to blend into the general population. *See id.* And, while they can sometimes manage in the community without comprehensive support, people in this group have a substantial disability, and function at a level lower than 97 percent of the general population. James W. Ellis et al. *Evaluating Intellectual Disability: Clinical Assessments in* Atkins *Cases*, 46 Hofstra L. Rev. 1305, 1327-28 (2018) [hereinafter *Evaluating ID*].

Criminal defendants with ID are almost always part of this subgroup, *Atkins Forensic Recommendations* at 142, and these are the people described in *Atkins v. Virginia* when the Court discussed the significant and pervasive deficits of people with ID in the criminal justice system. The Court noted that people with ID frequently know right from wrong and may be competent to stand trial, but it emphasized that "by definition they 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. . . . Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability." 536 U.S. 304 313, 318 (2002)

3. People with ID Often Mask Their Deficits.

People who have ID share the common human desire to be accepted and valued by others, but their disability often leads to significant stigma and exclusion instead. AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 52 (11th ed. 2010). To protect themselves, many people with ID develop a deeply ingrained, almost involuntary reflex to hide their deficits and appear more competent and functional than they actually are, even when revealing their disability would be beneficial. *Evaluating ID* at 1366-68 & nn.252-255 (discussing studies documenting the tendency of people with ID to 'mask' the disability whenever possible); Robert B. Edgerton, *The Cloak of Competence* (rev. ed. 1993) (an extensive study of the phenomenon of masking).

Among other common masking strategies, people with ID often rely on the assistance of others who manage tasks that they themselves cannot perform, such as reading or writing letters, performing basic financial transactions, understanding directions etc. *See* Robert B. Edgerton, *The Cloak of Competence* 155 (rev. ed.

1993) (explaining that to maintain themselves in the community, people with ID find 'benefactors' who help them with their problems).

4. People with ID Have Both Strengths and Weaknesses.

By definition, every person with ID has extensive deficits, but people with ID often have strengths as well. *AAIDD Diagnostic Manual 12th ed.* at 1 ("Within an individual, limitations often coexist with strengths."). While well known and documented by clinicians, this concept can clash with societal expectations and impressions about the abilities of someone with ID, which are often drawn from the more obvious disabilities of people in the moderate to profound range. *See Atkins Forensic Recommendations* at 142 ("[T]hose with mild [ID] who become involved in the criminal justice system typically do not exhibit stereotypical physical or behavioral characteristics commonly associated with severe [ID].").

Lay impressions notwithstanding, most people with ID who venture into the community on their own have some strengths. Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 121 (2009) ("Most individuals with [ID] will have strengths and areas of ability. These strengths may confound a layperson or a professional with limited clinical experience with individuals who have mild [ID]. These laypersons may erroneously interpret these pockets of strengths and skills as

inconsistent with [ID] because of their misconceptions regarding what someone with [ID] can or cannot do."). Reading, driving, graduating from high school, obtaining a GED, holding a job, playing games and sports, even marrying and having children are all within the abilities of some people with ID. *Evaluating ID* at 1403-04 & nn.379-82, 1405 n.383 (providing extensive lists of studies discussing strengths and abilities commonly found in this population).

However, the presence of such strengths does not somehow 'balance' or 'negate' deficits that are also present. In the diagnosis of ID, strengths cannot be weighed against deficits, and do not 'rule out' an ID diagnosis. Cecil R. Reynolds & Daneen A. Milam, *Challenging Intellectual Test Results*, in *Coping with Psychiatric and Psychological Testimony* 311, 330 (David Faust ed., 6th ed. 2012) (An individual with ID "cannot be disqualified from a diagnosis of [ID] based upon scattered strengths or skills."). The only relevant diagnostic question is whether the individual has deficits at the level required by the definition. *See Moore v. Texas*, 581 U.S. 1, 15 (2017) ("[T]he medical community focuses the adaptive-functioning inquiry on adaptive deficits.").

5. People with ID Often Have Co-Occurring Mental Illness.

At least 40 percent of people with ID also have a co-occurring mental illness. *AAIDD Diagnostic Manual 12th ed.* at 104-05. Having such a comorbid

mental illness cannot rule out a diagnosis of ID. *See Atkins Forensic Recommendations* at 152 ("[T]he presence of such a [mental illness] alone should not be assumed to account for observed deficient IQ scores, particularly when there is a history of intellectual limitations and adaptive behavior deficits."). But while mental illness should not preclude an ID diagnosis, it can make an evaluation more challenging. 'Diagnostic overshadowing' occurs when an individual has comorbid conditions and the most obvious problem obscures the presence of other concerns.[2] When someone with ID also has a mental illness, any dramatic symptoms of that illness may obscure the indicators of intellectual disability. American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 174 (10th ed. 2002). A clinician focused on reports of the hallucinations and delusions present in some mental illnesses may fail to recognize the co-occurring intellectual disability. *See* Thomas E. Gift, John S. Strauss & Barry A. Ritzler, *The Failure to Detect Low IQ in Psychiatric Assessment*, 135 Am. J. Psychiatry 345 (1978).

[2] See *Evaluating ID* at 1345-46 & nn.158-59 for a discussion of diagnostic overshadowing.

III. Diagnostic Issues

A. Stereotypes, Masking, or Diagnostic Overshadowing May Lead Some Clinicians to Make Errors in a Diagnostic Evaluation.

As they review prior records related to any of the three prongs of the definition, evaluators of *Atkins* claims must view reports of the examinee's functioning with caution, particularly reports from observers without clinical experience with ID. As explained *supra*, such observers may make false assumptions about abilities that a person with ID 'could' have, and hold misperceptions about those abilities and deficits the particular individual actually does have. *Evaluating ID* at 1406-07 & nn.384-89 (discussing the problem of lay informants and stereotypes). Misconceptions about the potential for abilities in people with ID, masking behaviors by the person with ID, and diagnostic overshadowing can all mislead observers, who may then report false conclusions about the abilities of the person in question.

An evaluating clinician who fails to investigate thoroughly may accept some or all of this faulty information, and then compound the error by also failing to recognize (or credit) the severity of the individual's actual deficits, attributing them to a lack of effort rather than a lack of ability. *Id.* at 1407 (Evaluators "should focus on specific, concrete observations of . . . limitations" because "[o]therwise,

there is a substantial risk that the assessment is built on a stereotype about intellectual disability of which the evaluator (and the court) may be unaware.").

B. Clinical Standards Regarding Psychological Testing.

1. The Intelligence Test Selected Must Be Appropriate.

Whenever possible, the intellectual functioning deficits required by prong 1 of the definition of ID should be measured using a current, valid, and standardized test specifically designed to measure intelligence. AAIDD, *Intellectual Disability: Diagnosis, Classification, and Systems of Supports* 35-42 (11th ed. 2010). An instrument chosen to measure the intelligence of someone who may have ID must have been normed and validated on a population that includes people with ID. *Evaluating ID* at 1351-52 & nn.186-88 (2018) (discussing studies and articles detailing the requirement of norming on relevant populations).

Currently, the Wechsler Adult Intelligence Scale series and the Stanford-Binet Intelligence Scale series are the principal tests that satisfy these requirements.[3] So-called 'short tests,' group tests such as those given in prison or in the military, and tests from which an IQ might be incidentally extrapolated are

[3] For an in-depth discussion of these tests and their qualifications, see *WAIS-IV Clinical Use and Interpretation* (Lawrence G. Weiss et al. eds., 2010) and Gale H. Roid & R. Andrew Barram, *Essentials of Stanford-Binet Intelligence Scales (SB5) Assessment* (2004).

not clinically acceptable choices for ID diagnosis and should not be used to rule out ID. *Id.* at 1354-57 & nn.199-208 (discussing studies documenting the inadequacy of short or group tests for the diagnosis of ID).

2. Scoring and Administration of Intelligence Tests Must Be Free of Errors.

Even appropriate testing instruments will produce invalid results if the clinician errs in administration, scoring, or interpretation of the test. This concern is heightened if the clinician is inexperienced, in training, or unfamiliar with people with ID. *See* Anne Anastasi & Susana Urbina, *Psychological Testing* 10-11 (7th ed. 1997)[4] Testing performed by an experienced and qualified professional can also be compromised by errors in administration and scoring. *Id.* at 11 ("In the absence of proper checking procedures, scoring errors are far more likely to occur than is generally realized."); *see also Evaluating ID* at 1351 & n.184 (collecting studies documenting the types and frequency of examiner error).

Moreover, the administrator's own expectations about the subject's

[4] The authors explain the "need for a qualified examiner" in the "selection of the test, administration and scoring, and interpretation of the scores." Examiners must understand "the need to follow instructions precisely," have a "thorough familiarity with the standard instructions," and keep "careful control of the testing conditions." Additionally, "incorrect or inaccurate scoring may render the test score worthless." Anne Anastasi & Susana Urbina, Psychological Testing 10-11 (7th ed. 1997).

capabilities can affect test results. *See* Paul A. McDermott, Marley W. Watkins & Anna M. Rhoad, *Whose IQ Is It?—Assessor Bias Variance in High-Stakes Psychological Assessment*, 26 Psychological Assessment 207, 208 (2014) ("Administration and scoring biases, most especially pervasive types, undermine the purpose of testing. Their corrupting effects are exponentially more serious when testing purposes are high stakes, and there is abundant evidence that such biases will operate to distort major score interpretations, to change results of clinical trials, and to alter clinical diagnoses and special education classifications."); *see also* Robert L. Schalock and Ruth Luckasson, *Clinical Judgment* 38 (2d ed. 2014) (discussing the problem of clinicians relying on stereotypes). Therefore, when a diagnosis of ID carries significant consequences, reviewing the raw test data—the scores on individual items and subtests, the examinee's responses, and any notes or other recordings concerning the testing—can be critical to validating the accuracy of the results, particularly if they diverge from the results of other such tests.

3. Successfully Malingering on Intelligence Tests Is Difficult.

Successfully malingering on an intelligence test is much more difficult than one might expect. IQ tests and manuals are not available to the general public, and so the examinee is unlikely to know much about the test content or process. Anne

Anastasi & Susana Urbina, *Psychological Testing* 10 (7th ed. 1997) ("There are two principal reasons for controlling the use of psychological tests: (a) to ensure that the test is given by a qualified examiner and that the scores are properly used; and (b) to prevent general familiarity with the test content, which would invalidate the test."). Further, all subtests of an instrument are not necessarily given in every circumstance. *Id.* at 207-210 (outlining the subtests and administration of the Stanford Binet and Wechsler tests). Additionally, the items in the subtests are generally progressive: each question is a little harder than the one before. *Id.* It would be very difficult for an untrained examinee to know precisely which subtests will be given, the order in which they will be given, or when to begin deliberately answering incorrectly. As a result, deliberately poor effort may be obvious and easily detectable to a trained examiner.[5]

4. People with ID May Be Falsely Identified as Malingerers by Some 'Effort Tests.'

Clinicians sometimes use 'effort testing' (commonly thought of as a 'malingering test') to assess the effort an examinee has put forth on a testing

[5] It is likely that it would be even more difficult to successfully malinger a similar score repeatedly on separate tests taken over a period of years. For each test, a successful malingerer would have to know the subtests and the questions, memorize the subtests and questions administered, and later remember which questions were answered correctly and which were not.

battery. *See* Christopher L. Ray et al., *Assessment of Feigned Cognitive Impairment: A Cautious Approach to the Use of the Test of Memory Malingering for Individuals with Intellectual Disability*, 4 Open Access J. Forensic Psychology 24, 25-26 (2012) [hereinafter Ray, *A Cautious Approach*]. As with all psychological tests, effort tests must be validated and normed on a wide cross-section of the population; if a test has not been normed on a particular subgroup of the population, using it on an individual from that subgroup risks producing invalid results. AAIDD, *User's Guide to Accompany the 11th Edition of Intellectual Disability: Definition, Classification, and Systems of Supports* 24 (2012).[6] Effort tests which have not been normed on people with ID may be falsely interpreted as showing that an individual with ID is malingering, and should not be used with an individual who has ID. Ray, *A Cautious Approach* at 34 (discussing the high likelihood of false-positive error when a test not normed on people with ID is used

[6] AAIDD explains that "[c]linicians who... attempt to use specific 'malingering' tests in individuals with ID must use considerable caution because of two factors: (1) the lack of a research base supporting the accuracy of such tests for persons with ID; and (2) the documented misuse of common malingering tests even when the test manual explicitly precludes use with individuals with ID. Standardized assessment instruments used to inform the clinician whether the person is putting forth his or her best effort (i.e., malingering) have not, for the most part, been normed for persons with ID." AAIDD, *User's Guide to Accompany the 11th Edition of Intellectual Disability: Definition, Classification, and Systems of Supports* 24 (2012).

to evaluate someone with that disability).

The Test of Memory Malingering (TOMM) is one of the effort tests that was not normed on people with ID. *Id.* at 35. While some authorities suggest the test should not be used with the ID population at all, others have found that if the test is used with a person who has ID, a scoring cut-off lower than the one in the manual should be employed. *Id.* at 35-40; s*ee also* Kolleen E. Hurley & William Paul Deal, *Assessment Instruments Measuring Malingering Used with Individuals Who Have Mental Retardation: Potential Problems and Issues*, 44 Mental Retardation 112, 116 (2006) (explaining that forty-one percent of people with ID were falsely identified as malingering using the cut-off scores in the TOMM manual.). If clinicians adhere to the cut-off score suggested in the manual, people with ID may give full effort on this test but obtain a score that indicates malingering. The studies indicate that on this test, a conclusive decision that someone with ID is deliberately malingering should only be made if the individual's score is below chance. Ray, *A Cautious Approach* at 40. In other words, the person must get so many answers wrong that statistically they must be deliberately choosing the wrong answer, not just guessing incorrectly.

C. "Manifestation During the Developmental Period" Does Not Require a Diagnosis, (or Even Testing) During That Time.

While the third prong of the definition requires that the individual have shown intellectual and adaptive functioning problems during the developmental period, it does not require psychometric testing or a formal diagnosis during that time. Matthew H. Scullin, *Large State-Level Fluctuations in Mental Retardation Classifications Related to Introduction of Renormed Intelligence Test*, 111 Am. J. Mental Retardation 322, 331 (2006) ("There is no professionally recognized requirement for a developmental period classification of [ID] or developmental period IQs in the ID range from childhood to establish [ID]"). Any such requirement would wrongly prevent diagnosis for people who meet the criteria, solely because they lacked access to clinical testing during childhood. *Id.* at 332 ("[M]any adults who currently meet the IQ and poor adaptive functioning criteria necessary for being classified with [ID] may have never received a formal developmental period classification."). Because ID is a life-long condition, a diagnosis based on information gathered after the developmental period is valid when it is done according to clinical standards and best practices. *See* Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 115 (2009) ("'[O]riginated

during the developmental period' does not preclude making a first time diagnosis of [ID] when an individual is an adult. The clinician must, however, adequately document that the deficits in intellectual and adaptive functioning were present before the end of the developmental period.").

CONCLUSION

A valid *Atkins* evaluation requires an accurate assessment of intellectual disability. Adherence to clinical standards when evaluating information regarding the three prongs of the ID definition is essential for an accurate diagnosis. Failure to follow accepted clinical standards in an *Atkins* evaluation may create a clinically—and legally—unreasonable determination of the facts supporting the diagnostic criteria, and result in the execution of a person with ID, in violation of the Eighth Amendment.

Date: August 29, 2023

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CERTIFICATE OF COMPLIANCE

I hereby certify as follows:

1. The foregoing Brief complies with the type-volume limitation of Circuit Rule 29-2(c) (2). The Brief is printed in proportionally spaced 14-point type, and there are 4,148 words in the Brief according to the word count of the word-processing system used to prepare the Brief (excluding the parts of the Brief exempted by Fed. R. App. P. 32(f)).
2. The Brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5), and with the type style requirements of Fed. R. App. P. 32(a)(6). The Brief has been prepared in a proportionally spaced typeface using Microsoft Office Word 2016 in 14-point Times New Roman.

Date: August 29, 2023

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CERTIFICATE OF SERVICE

I hereby certify that on August 29, 2023, I electronically filed the foregoing with the Clerk of the Court for the U.S. Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system:

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Date: August 29, 2023

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