No. 08-6631

# In The Supreme Court of the United States

JOSE GARCIA BRISENO,

*Petitioner,*

versus

NATHANIEL QUARTERMAN,
Director, Texas Department of Criminal Justice,
Correctional Institutions Division,

*Respondent.*

**On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit**

## BRIEF OF THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (AAIDD) AND THE ARC OF THE UNITED STATES AS *AMICI CURIAE* IN SUPPORT OF PETITIONER


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## INTEREST OF *AMICI CURIAE*[1]

**The American Association on Intellectual and Developmental Disabilities (AAIDD)** (formerly The American Association on Mental Retardation, AAMR), founded in 1876, is the Nation's oldest and largest organization of mental disability professionals in the field of mental retardation.[2] AAIDD has longstanding concerns about constitutional and statutory protections for people with mental disabilities, and mental retardation in particular, in the criminal justice system. AAIDD (as the AAMR) has appeared as *amicus curiae* before this Court in numerous cases, including *Atkins v. Virginia*, 536 U.S. 304 (2002).

AAIDD is also the organization that has formulated the professionally accepted definition of mental retardation that is used by professionals in every state. Its definition has also been used by this Court

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[1] This brief was written entirely by counsel for *amici*, as listed on the cover, and not by counsel for any party. No outside contributions were made to the preparation or submission of this brief. The parties were notified ten days prior to the due date of this brief of the intention to file. All parties have given written consent to the filing of this brief.

[2] Clinicians increasingly employ the term "intellectual disability." This brief refers to "mental retardation," since *Atkins* employs that term. *See* Robert L. Schalock et al., *The Renaming of* Mental Retardation: *Understanding the Change to the Term* Intellectual Disability, 45 Intell. & Developmental Disabilities 116 (2007) (explaining that change in terminology within AAIDD involves no change in definition).

in resolving cases involving a number of legal issues that affect people with mental retardation. *See, e.g., Atkins v. Virginia*, 536 U.S. at 308 n.3; *Heller v. Doe*, 509 U.S. 312, 322 (1993); *Penry v. Lynaugh*, 492 U.S. 302, 308 n.1 (1989); *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 442 n.9 (1985). Both as the formulator of the professional definition and as an organization vitally concerned about maintaining appropriate professional standards in the diagnosis of mental retardation, AAIDD has a strong interest in the manner in which *Atkins* claims are evaluated by the courts.

**The Arc of the United States** is the world's largest community based organization of and for people with intellectual and developmental disabilities. The Arc of the United States advocates for the rights and full participation of all children and adults with intellectual and developmental disabilities. It provides an array of services and support for families and individuals and includes over 140,000 members affiliated through more than 850 state and local chapters across the nation. The Arc is devoted to ensuring the civil rights of and promoting and improving supports and services for all people with intellectual and developmental disabilities.

## SUMMARY OF ARGUMENT

This Court has made clear that the Eighth Amendment prohibits the execution of individuals

who have mental retardation. The responsibility for crafting the procedures under which courts will determine whether a defendant has mental retardation have been left, in the first instance, to the States. The majority of the States have had relatively little difficulty in establishing procedures that are designed to assure even-handed evaluation of individual claims.

A few states, however, in addition to selecting implementing procedures, have crafted their own substantive definitions of mental retardation that are incompatible with the scientific and clinical understanding of developmental disability. Whether by design or accident, the result is that many individuals who clearly meet the accepted clinical definition of mental retardation are at risk of being sentenced to death and executed. Texas is such a state.

States that adopt non-clinical, non-scientific, and idiosyncratic definitions of mental retardation are abusing the responsibility entrusted to them in *Atkins*, and are defying the clear constitutional mandate from this Court. *Amici* agree with Petitioner that the Texas standards and procedures are inconsistent with the accepted and established scientific understanding of mental retardation. Petitioner's complaints about the misuse and misunderstanding of IQ tests are fully justified and need no amplification here. For this reason, *amici* focus entirely on misapplication of the adaptive behavior prong. Because the lower courts' treatment of that prong relies on false stereotypes about mental retardation, it

grossly deviates from the clinical definition. Moreover, because similar deviations have occurred in a few other states, again due to the reliance on false stereotypes, this deviation from the clinical definition must be addressed before it is allowed to erode the protection promised by *Atkins*.

## REASONS THE WRIT SHOULD BE GRANTED

### I. INTRODUCTION

In *Atkins v. Virginia*, 536 U.S. 304 (2002), this Court held that the consistent wave of state legislative action after *Penry v. Lynaugh*, 492 U.S. 302 (1989), established a national consensus against executions of persons with mental retardation. *Atkins*, 536 U.S. at 313-16. In doing so, the Court embraced the clinical definitions of mental retardation accepted by the AAMR (now the AAIDD) and the American Psychiatric Association. *See Atkins*, 536 U.S. at 309 n.3, 317 n.22. Thus, under *Atkins*, the Eighth Amendment protects those individuals who meet the AAIDD/AAMR criteria, or the virtually identical criteria of the Diagnostic and Statistical Manual of Mental Disorders. *See* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 41 (4th ed. text rev. 2000) [hereinafter DSM-IV-TR].

Since *Atkins*, most jurisdictions have adopted and applied the appropriate clinical definitions. A few states, however, have taken *Atkins*'s statement that

lower courts and state legislatures may adopt their own procedures for "enforc[ing] the constitutional restriction," *Atkins*, 536 U.S. at 317 (quoting *Ford v. Wainwright*, 477 U.S. 399 (1986)), as license to embrace definitions of mental retardation that deviate from, and are more restrictive than, accepted clinical definitions and practices. These deviations from the clinical understanding of mental retardation have had the effect of excluding some individuals who clearly fall within the class protected by *Atkins*. Several of these states, including Texas, are among the states that this Court identified as holdouts to the national consensus. *Id.* at 316 n.20. The reluctance of Texas courts to follow this Court's mandate in *Atkins* echoes their decade-long resistance to this Court's clear teachings in *Penry v. Lynaugh*, 492 U.S. 302 (1989) ("*Penry I*"). *See, e.g.*, *Tennard v. Dretke,* 542 U.S. 274 (2004); *Penry v. Johnson*, 532 U.S. 782 (2001) ("*Penry II*").[3]

*Amici* submit this brief to provide the Court with the accepted principles underlying the clinical definition of mental retardation, and to contrast the lower court decisions in this case – and others – with those principles. If not corrected by this Court, the state and federal court opinions in *Briseno*, *see Briseno v. Dretke*, No. Civ. A. L-05-08, 2007 WL 998743 (S.D. Tex. Mar. 29, 2007); *Ex parte Briseno*, 135 S.W.3d 1

[3] *Amici* in the present case were among the *amici* before this Court in the cases seeking compliance with the holding of *Penry I*.

(Tex. Crim. App. 2004), may become a source of misunderstanding of mental retardation for other courts, and a roadmap for those courts that wish to deny *Atkins* relief to a defendant whose condition clearly falls within the clinically accepted definition.

This case provides the Court with an appropriate vehicle to remind lower courts that fidelity to the holding of *Atkins* requires even-handed application of the definition *Atkins* embraced, and requires adherence to the scientific and clinical understanding of mental retardation that are its foundation. While *Atkins* allowed state legislatures and courts to adopt procedures for "enforcing the constitutional restriction," *Atkins*, 536 U.S. at 317, it did not give states license to narrow the class of persons who fall within the constitutional prohibition and to exclude some who, in fact, have mental retardation. Unless the Court acts to affirm *Atkins*'s meaning, persons whom any reasonable clinician would deem to have mental retardation will be erroneously and unconstitutionally determined to be death eligible.

## II. THE DEFINITION AND CLINICAL UNDERSTANDING OF MENTAL RETARDATION.

The AAIDD definition of mental retardation is the starting point for any discussion of appropriate diagnosis or classification. The definition provides: "Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual,

social, and practical adaptive skills. This disability originates before age 18." AAMR, *Mental Retardation: Definition, Classification, and Systems of Supports* 1 (10th ed. 2002) [hereinafter AAMR 2002].[4]

This definition has three prongs.

The first prong involves intellectual functioning, and a "significant limitation" in intellectual functioning requires that the measured intelligence of the individual fall at least two standard deviations below the mean.[5] The measurement of intellectual

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[4] This definition encompasses the same group of individuals as previous definitions propounded by AAMR. *See, e.g.,* AAMR, *Mental Retardation: Definition, Classification, and Systems of Supports* 1 (9th ed. 1992). It also follows the same basic contours as the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. *See* DSM-IV-TR, *supra*, at 41.

[5] *Atkins* noted that "an IQ between 70 and 75 or lower . . . is typically considered the cutoff IQ score for the intellectual function prong of the mental retardation definition." 536 U.S. at 309 n.5 (citing 2 *Kaplan & Sadock's Comprehensive Textbook of Psychiatry* 2952 (B. Sadock & V. Sadock eds., 7th ed. 2000)). The same requirement that measured intelligence fall within a range below an IQ of 70 to 75 was also found in previous editions of the AAMR manual. *See, e.g.,* AAMR, *Mental Retardation: Definition, Classification, and Systems of Supports* 14 (9th ed. 1992) (defining significantly subaverage intellectual functioning as "approximately 70 to 75 or below"). It is also consistent with the requirements of the American Psychiatric Association's diagnostic manual.

> Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below. . . . It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may

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functioning is evaluated through careful assessment of the individual's scores on IQ tests. These psychometric instruments allow an experienced clinician to assess whether the individual meets the requirements of the definition's first prong. Since there are minor differences in scoring among the IQ tests employed, and because other factors can affect the reliability of the raw IQ score, the clinical judgment of an experienced mental retardation professional is essential in assuring accuracy in the interpretation of test results. Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 5-6 (AAMR, 2005).

The second prong of the definition requires that an individual must have significant limitations in adaptive behavior in order to be classified as having mental retardation. This requirement is designed to make sure that the individual's IQ score is a reflection of a real-world disability, and not merely a testing anomaly. The focus of the clinical inquiry regarding this second prong is to determine whether there are significant things that the individual being

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> vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior.

DSM-IV-TR, *supra*, at 41-42. *See also* American Psychological Association, *Manual of Diagnosis and Professional Practice in Mental Retardation* 15 (John W. Jacobson and James A. Mulick eds., 1996).

evaluated cannot do that someone without his disability can do. Because a gross misunderstanding of this prong of the definition is at the heart of the erroneous judgments by the courts below in this case, and of the erroneous guidance that other lower courts will glean from the *Briseno* opinions, *amici* focus on the adaptive functioning prong in the remainder of this brief.

The third prong of the definition requires that the disability manifested at birth or during the individual's childhood. Application of the third prong is not at issue at all in *Briseno*.

This Court has correctly observed that diagnosing whether an individual has mental retardation is less complex than the diagnosis of many forms of mental illness. *Heller*, 509 U.S. at 321-22. Moreover, there are objective measures of intellectual functioning (IQ tests), as well as a history of performance, behavior, and observations by others regarding deficits in adaptive skills. Individual assessment, however, still requires careful clinical judgment. Schalock & Luckasson, *supra,* at 5-6. Consequently, it is crucial to prevent stereotypes about people who have mental retardation from clouding or distorting individual assessment.[6]

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[6] The problems caused by stereotyping have long been recognized in the field of mental retardation. *See, e.g.*, Michael S. Sorgen, *The Classification Process and its Consequences,* in *The Mentally Retarded Citizen and the Law* 215, 215-16 (Michael Kindred et al., eds., 1976). False stereotypes have played a major role in buttressing the cruel and discriminatory treatment

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## III. THE ROLE OF ADAPTIVE BEHAVIOR IN MENTAL RETARDATION EVALUATIONS.

### A. Evaluations of adaptive functioning under the clinical definition of mental retardation necessarily focus on the individual's *deficits*.

To fall within the definition of mental retardation, an individual's diminished intellectual functioning must involve actual impairment in the skills involved in everyday living. As this Court has observed, "those who are mentally retarded have a reduced ability to cope with and function in the everyday world." *Cleburne*, 473 U.S. at 442. The task of courts evaluating *Atkins* claims includes determining whether the reduced intellectual ability indicated

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individuals with mental retardation have too often received. *See generally Cleburne*, 473 U.S. at 454 (Stevens, J., concurring) ("[A] history of unfair and often grotesque mistreatment."); James W. Trent, Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (1994) (describing the evolving definition of mental retardation and the stereotypes associated with developmental disability). False stereotyping prompted leaders of our field in the eugenics era to claim, for example, that "[t]he feeble-minded are a parasitic, predatory class, never capable of self-support or of managing their own affairs. . . . They cause unutterable sorrow at home and are a menace and danger to the community." Walter Fernald, *The Burden of Feeblemindedness*, 17 J. Psycho-Aesthenics 87, 90 (1912). History has thoroughly discredited such views. It is similarly false to assume or conclude that every person who has mental retardation possesses the same lack of skills or abilities. *See infra* note 8.

by IQ testing had a significant impact on the individual's practical skills and functioning.[7]

The adaptive behavior prong of the definition focuses on "significant *limitations* . . . in adaptive behavior." AAMR 2002, *supra,* at 1 (emphasis added); *see* DSM-IV-TR, *supra,* at 41 ("[S]ignificant *limitations* in adaptive functioning.") (emphasis added).[8] Thus, determining deficits in "adaptive behavior" involves the assessment of what it is that the person with intellectual impairment *cannot* do. A person with mental retardation will lack some basic skills and abilities that non-disabled individuals typically possess. However, not every individual with mental retardation will be unable to do the *same* things. This Court has long acknowledged "wide variation in the

[7] This may occur in two related ways. "Low intellectual abilities may be responsible for both problems in acquiring adaptive behavior skills (acquisition deficit) and/or with the appropriate use of skills that have been learned (performance deficit)." AAMR 2002, *supra*, at 75.

[8] This focus on the individual's limitations has long been part of the definition of mental retardation. Earlier clinical formulations of the definition also consistently expressed the adaptive prong in the negative. *See, e.g.*, AAMR, *Mental Retardation: Definition, Classification, and Systems of Supports* 1 (9th ed. 1992) ("*limitations* in two or more of the . . . applicable adaptive skill areas"); American Association on Mental Deficiency [AAMD, now AAIDD], *Classification in Mental Retardation* 184 (Herbert J. Grossman ed., 1983) ("*deficits* in adaptive behavior") (emphasis added); AAMD, *Manual on Terminology and Classification in Mental Retardation* 5 (1973) ("*deficits* in adaptive behavior") (emphasis added); *see also Atkins*, 536 U.S. at 308 n.3 (adopting the clinical formulations).

abilities and needs" of people with mental retardation. *Cleburne*, 473 U.S. at 445. Individuals with intellectual impairment at approximately the same level often have quite different adaptive behavior deficits.

Individuals who have mental retardation – like all individuals – differ substantially from one another. For each individual with mental retardation, there will be things he cannot do, but also things that he *can* do. It is one of the fundamental precepts of the field of mental retardation that "[w]ithin an individual, limitations often coexist with strengths." AAMR 2002, *supra*, at 1. Because the mixture of skills and skill deficits varies widely among persons with mental retardation, there is no clinically accepted list of common, ordinary skills or abilities that preclude a diagnosis of mental retardation. Consequently, any conclusion that a defendant could not have mental retardation because he was able to engage in a particular common activity (such as driving a car, or getting married or holding a job) is unsupported by, and, totally at odds with, the well accepted clinical understanding of mental retardation.[9]

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[9] Dr. Mears's testimony in Jose Briseno's case, upon which the courts below relied, is a particularly egregious example of the use of non-clinical definitions of mental retardation. He perceived "the mentally retarded" as people who cannot use a phone, cannot go to the bathroom, and cannot eat or dress themselves. *See* Reporter's Record of *Atkins* Hearing Transcript, Vol. 4, pp. 51-52 ("His daily living thing, can he drink from a cup? Can he suck from a straw? Can he feed himself with a fork?

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Thus, the focus in assessing an individual's adaptive behavior must be on *deficits* in adaptive behavior, rather than strengths. There is simply no clinical or scientific support for the conclusion that the existence of some skills or abilities precludes the diagnosis of mental retardation. For courts to rule otherwise, and to conclude that a defendant was excluded from the protection of this Court's decision in *Atkins* because of an impression or belief that people with mental retardation are all incapable of a particular task or activity, disconnects *Atkins* from its scientific mooring. It also permits the life or death decision about an individual with an intellectual disability to be based on the same type of false stereotypes that have burdened people with mental retardation for generations. *See Cleburne*, 473 U.S. at 454-55 (Stevens, J., concurring) (observing that people with mental retardation "have been subjected to a history of unfair and often grotesque mistreatment"). Such mistreatment often results from archaic stereotypes. *See generally*, *United States v. Virginia*, 518 U.S. 515, 541 (1996) (warning of "fixed notions" about gender roles and abilities); *Mississippi University for Women v. Hogan*, 458 U.S. 718, 725 (1982) (rejecting "archaic and stereotypic notions" about gender roles).

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Is toilet training – is he toilet trained or not? These are very basic things that mentally retarded people have a problem with. If they didn't have a problem with these basic things, they wouldn't be called mentally retarded."). These are precisely the kinds of false stereotypes that have plagued the field of mental retardation for many years. *See supra* note 6.

### B. The significance of co-existing mental illness.

Mental retardation and mental disorders often coexist. Put differently, a substantial number of individuals who have mental retardation also have some form of mental illness. In fact, "[i]ndividuals with Mental Retardation have a prevalence of comorbid mental disorders that is estimated to be *three to four times greater* than in the general population." DSM-IV-TR, *supra,* at 45 (emphasis added); *see* AAMR 2002, *supra,* at 172 ("[M]ental health disorders are much more prevalent [among individuals with mental retardation than] the general population.").[10] Correctly evaluated, this phenomenon produces a "dual diagnosis."

The characteristics that this Court identified in *Atkins* that make defendants with mental retardation less culpable – "diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others," *Atkins*, 536 U.S. at 318 – do overlap with the criteria for some mental illnesses.[11] Some courts have used this overlap as a

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[10] The phenomenon of co-existing mental illness and mental retardation is not new, and is well-documented in the clinical literature. *See, e.g.*, *Handbook of Mental Illness in the Mentally Retarded* (Frank J. Menolascino & Jack A. Stark eds., 1984).

[11] Characteristics of mental retardation overlap, for example, with the diagnostic criteria for antisocial personality

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basis for rejecting a valid *Atkins* claim, dismissing manifestations of limited functioning as attributable to mental illness *rather than* mental retardation. For example, in this case, Dr. Mears concluded that the manifestations of limited functioning were attributable to antisocial personality disorder, and therefore did not count toward demonstrating the existence of adaptive functioning deficits. This approach is directly contrary to accepted clinical practice.

The general comorbidity literature recognizes that when dual diagnoses are present, there is always a risk of "diagnostic overshadowing." AAIDD, *User's Guide: Mental Retardation: Definition, Classification, and Systems of Supports* 16 (2007).[12] In particular, with mental retardation, there is a risk of "under-recognition of intellectual impairments among individuals with depression, psychosis, or anxiety

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disorder, which is defined by factors including "failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest"; "impulsivity or failure to plan ahead"; "consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations"; and "lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another." DSM-IV-TR, *supra*, at 706.

[12] The phenomenon of diagnostic overshadowing, and the attendant risk that the existence of mental illness may lead diagnosticians to fail to recognize an individual's mental retardation, has long been recognized in the clinical literature. *See, e.g.*, Steven Reiss & J. Szyszko, *Diagnostic Overshadowing and Professional Experience with Mentally Retarded Persons*, 87 Am. J. Mental Deficiency 396 (1983).

disorders." *Id*. To avoid under-recognition of mental retardation, the clinical definitions affirm that "the diagnosis should be made whenever the diagnostic criteria are met, *regardless of and in addition to the presence of another disorder*." DSM-IV-TR, *supra,* at 47 (emphasis added). "The diagnostic criteria for Mental Retardation do not include an exclusion criterion." *Id*.

The courts below clearly misunderstood the definition of mental retardation and wrongly believed that Petitioner was not entitled to relief under *Atkins* because some of the manifested deficits in his adaptive behavior were also symptomatic of antisocial personality disorder. Such a conclusion is unsupported by the clinical literature and, if allowed to stand, will render a significant number of individuals with mental retardation at risk of being wrongfully sentenced to death and executed.

## IV. LOWER COURTS DIVERGE IN THEIR ACCEPTANCE OF THE CLINICAL UNDERSTANDING OF THE DEFINITION OF MENTAL RETARDATION.

Most states and federal courts have faithfully applied *Atkins*, and their decisions correctly reflect the clinical understanding of adaptive functioning deficits. Some have even explicitly rejected the kind of errors made by the Texas courts. For example, the Ohio Supreme Court reversed a lower court determination that the defendant did not have mental

retardation where that finding had been based on stereotypes about what an individual with the disability could not do and what he might look like. *State v. White*, 885 N.E. 2d 905, 915 (Ohio 2008) ("There was no evidence that bizarre behavior is a necessary attribute of the mentally retarded."); *id.* ("Especially relevant here is Dr. Hammer's already cited observation that retarded individuals '*may look relatively normal in some areas* and have significant limitations in other areas.'") (emphasis in original). In Alabama, a federal district court reversed a state court finding of no mental retardation, faulting the prosecution's expert for "look[ing] upon inappropriate conduct as something separate from mental retardation, rather than as indicating a lack of support which has impeded adaptation." *Holladay v. Campbell*, 463 F. Supp. 2d 1324, 1344 (N.D. Ala. 2006); *see id*. at 1345 ("This court rejects the argument that willful and anti-social behavior excludes a mental retardation determination. To the contrary, it suggests that a person whose IQ tests strongly indicate mental retardation has not adapted."). Similarly, in Oklahoma, the Court of Criminal Appeals held that because evidence concerning mental disorders did not offset the alleged adaptive behavior limitations, it was irrelevant to the mental retardation determination. *Lambert v. State*, 126 P.3d 646, 659 (Okla. Crim. App. 2005) ("Mental retardation and mental illness are separate issues. It is possible to be mentally retarded and mentally ill."); *id.* at 651 ("Unless a defendant's evidence of particular limitations is specifically contradicted by evidence that he does not

have those limitations, then the defendant's burden is met no matter what evidence the State might offer that he has no deficits in other skill areas.").

Some lower courts, however, like those in this case, have rejected clinical understandings of mental retardation and erroneously rejected *Atkins* claims, either relying on archaic stereotypes about the abilities of people with mental retardation, or misinterpreting the presence of mental illness. For example, in another Texas case, courts denied *Atkins* relief because "evidence of a strength in a particular area of adaptive functioning *necessarily* shows that the defendant does not have a weakness in that particular area." *Clark v. Quarterman,* 457 F.3d 441, 447 (5th Cir. 2006) (emphasis added). Likewise, a Florida court found that a mental retardation diagnosis "was contradictory to the evidence that Brown was engaged in a five-year intimate relationship prior to the crime, that he had his driver's license and drove a car, and that he was employed in numerous jobs including as a mechanic." *Brown v. State*, 959 So.2d 146, 150 (Fla. 2007). And in Mississippi, *Atkins* relief was denied based on what the defendant could do, rather than what he could not. *Wiley v. State*, 890 So.2d 892, 897 (Miss. 2004) ("These reports, affidavits and testimonies do not paint the picture of a retarded person."), *aff'd*, *Wiley v. Epps*, No. 2:00CV130-P-A, 2007 WL 405041, at *34-40 (N.D. Miss. Feb. 2, 2007). Furthermore, several Texas cases follow the clinically disavowed view that mental retardation and personality disorder are mutually exclusive, *see, e.g., Williams*

*v. Quarterman*, No. 07-70006, 2008 WL 4280315, at *13-14 (5th Cir. Sept. 19, 2008); *Neal v. State*, 256 S.W.3d 264, 274-75 (Tex. Crim. App. 2008), and a recent Louisiana case takes the same erroneous approach. *Brumsfield v. Cain*, No. 04-787-JJB-CN, 2008 WL 2600140 (M.D. La. June 30, 2008) (affirming reasonableness of trial court determination where evidence "indicated that a significant part of Brumfield's difficulties actually stem from his attention deficit disorder . . . which, while it results in an inability to focus, is not equivalent to mental retardation").

Petitioner's case presents a particularly appropriate vehicle for this Court to affirm the holding of *Atkins*, and to correct lower courts that have taken this Court's instruction to devise appropriate procedures as tacit permission to improvise non-clinical substantive standards more to their liking. Not only does the Petition establish that this is a particularly egregious example of arbitrarily narrowing the class of defendants who are entitled to constitutional relief, but this case, unless reviewed, will exacerbate misunderstanding of *Atkins* in other courts. The opinion of the Texas Court of Criminal Appeals in *Briseno*, perhaps because of its so-called list of "factors" to resolve questions about adaptive behavior, *see Ex parte Briseno*, 135 S.W.3d 1, 8-9 (Tex. Crim. App. 2004), has caught the attention of courts in other states. *See, e.g.*, *Van Tran v. State*, No. W200501334CCAR3PD, 2006 WL 3327828, at *23-24 (Tenn. Crim. App. Nov. 9, 2006). This list of "factors," as Petitioner conclusively demonstrates, has no basis

of support in the clinical literature or in the understanding of mental retardation by experienced professionals in the field, but nonetheless is being cited by other courts. Were this Court to delay affirmation of its ruling in *Atkins* for another day, during the interim, defendants with legitimate claims to constitutional exemption may, like Petitioner, face execution.

## CONCLUSION

The decision in *Briseno v. Quarterman* reflects a fundamental misunderstanding of the accepted clinical definition of mental retardation. Such rogue definitions create the likelihood that, in some states, defendants whom any competent clinician would find to have mental retardation will be found to be death eligible. Therefore, *amici* ask this Court to grant certiorari to insist upon faithful adherence to its decision in *Atkins*.

Respectfully submitted,

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