No. 15-797

In the Supreme Court of the United States

BOBBY JAMES MOORE,
Petitioner,

v.

STATE OF TEXAS,
Respondent.

On Writ of Certiorari to the Texas Court of Criminal Appeals

BRIEF OF THE STATES OF ARIZONA, ALABAMA, ARKANSAS, COLORADO, FLORIDA, GEORGIA, IDAHO, KANSAS, LOUISIANA, MISSOURI, NEVADA, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, TENNESSEE, AND UTAH AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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CAPITAL CASE

QUESTION PRESENTED

In *Atkins v. Virginia*, 536 U.S. 304 (2002), this Court held that the Eighth Amendment prohibits the execution of intellectually disabled capital offenders and expressly "le[ft] to the State[s] the task of developing appropriate ways to enforce the constitutional restriction." *Id.* at 317.

The question presented is: Does the Eighth Amendment prohibit the States from taking any meaningful role in defining intellectual disability for enforcement of *Atkins'* constitutional restriction and require them to adopt standards that strictly conform to professional medical associations' most current clinical definitions of intellectual disability?

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INTEREST OF *AMICI CURIAE*

The States *amici curiae*, through their Attorneys General, respectfully submit this brief in support of Respondent. The States have a vital interest in the administration of criminal justice, particularly regarding capital crimes committed in their jurisdictions. *See Oregon v. Ice*, 555 U.S. 160, 170 (2009) ("[T]he authority of States over the administration of their criminal justice systems lies at the core of their sovereign status."). When this Court decided *Atkins*, it expressly "le[ft] to the State[s] the task of developing appropriate ways to enforce the constitutional restriction" on capital punishment for intellectually disabled offenders. *Atkins v. Virginia*, 536 U.S. 304, 317 (2002). And in *Hall*, the Court emphasized that "[t]he legal determination of intellectual disability is distinct from a medical diagnosis." *Hall v. Florida*, 134 S. Ct. 1986, 2000 (2014). This case tests the continuing validity of these principles.

Petitioner—and his *Amici*—contend that the States have no role to play in defining the substantive criteria for determining when an offender otherwise eligible for the death penalty is intellectually disabled and thus falls within *Atkins*' Eighth Amendment restriction. In their view, the sole responsibility for defining this constitutional standard rests with private associations comprised of mental health professionals, and any state law that does not strictly adhere to these associations' most current clinical standards violates the Eighth Amendment. A decision in favor of Petitioner would have the unprecedented result of stripping the States of their ability to play any part in crafting substantive

criteria for sentencing offenders convicted of capital murder. Such a decision would substantially impact crucial State interests in decision-making concerning traditional police powers. Furthermore, it would hinder the creation of workable intellectual disability standards in the context of capital punishment, as well as finality and closure for murder victims' families.

SUMMARY OF ARGUMENT

Petitioner's challenge to Texas' framework for determining intellectual disability claims rests on the premise that *Atkins* and *Hall* sideline the States from playing any meaningful role in creating the legal standards for implementing the constitutional restriction against executing intellectually disabled offenders. According to Petitioner and his *Amici*, the States are constitutionally mandated to employ most recent clinical, diagnostic criteria developed by mental health organizations for determining intellectual disability. They argue, therefore, that because Texas does not strictly follow the most recent clinical practices, its law contravenes *Atkins*, *Hall*, and the Eighth Amendment.

Additionally, *Amicus* The Constitution Project contends that Texas' standards for determining whether an offender is intellectually disabled render it an "outlier" among the States, suggesting there is a national consensus establishing its invalidity.

Both contentions fail.

First, a review of the standards employed by the States for determining intellectual disability in capital cases makes clear that although the States use standards and definitions that are informed by the

medical profession, the overwhelming majority of death penalty States have declined to embrace wholesale the medical profession's very latest clinical standards. Because there is no "national consensus" among the States contrary to Texas' challenged framework, Texas is not an "outlier" and the "clearest and most reliable objective evidence of contemporary values" fails to support any claim that it is unconstitutional. *See Hall*, 134 S. Ct. at 2002 (quoting *Penry v. Lynaugh*, 492 U.S. 302, 331 (1989)).

Furthermore, *Atkins* and *Hall* did not limit the States' role to the rote administrative task of simply amending their statutes to conform each time the American Psychiatric Association ("APA") or American Association on Intellectual and Developmental Disabilities ("AAIDD") publishes new clinical criteria for diagnosing intellectual disability. Contrary to Petitioner's assertions, neither case held that "current diagnostic criteria" constitute the constitutional standard for implementing the Eighth Amendment ban on capital punishment for the intellectually disabled.

Rather, in *Atkins*, this Court explicitly left to the States the responsibility for creating substantive and procedural criteria for implementing the Eighth Amendment restriction. Then, in *Hall*, although it concluded that Florida's failure to account for standard error of measurement in IQ testing violated the Eighth Amendment, the Court nonetheless emphasized that intellectual disability's legal determination is distinct from a medical diagnosis. The Court's recognition of the States' crucial role in creating substantive criteria for important legal determinations is consistent with its precedent in other contexts, which acknowledges that,

while relevant professional associations may develop standards that inform or guide legal analysis, they do not govern. Nor should they; policy demands that the States, not private professional associations, hold the ultimate responsibility for drafting important legal standards, especially in the administration of criminal justice.

ARGUMENT

I. THERE IS NO "NATIONAL CONSENSUS" AMONG THE STATES EMBRACING MEDICAL ASSOCIATIONS' VERY LATEST DIAGNOSTIC STANDARDS FOR INTELLECTUAL DISABILITY.

A. Texas' intellectual disability criteria reflect the guidance of professional medical associations while not strictly adhering to clinical practices.

After *Atkins*, the Texas Court of Criminal Appeals adopted the definition of intellectual disability then used by the American Association on Mental Retardation ("AAMR," now the AAIDD) and a similar definition included in the Texas Health and Safety Code. *Ex parte Briseno*, 135 S.W.3d 1, 7 (Tex. Crim. App. 2004); *see also Ex parte Moore*, 470 S.W.3d 481, 486 (Tex. Crim. App. 2015). That definition of intellectual disability includes three prongs: (1) significantly subaverage intellectual functioning; (2) accompanied by related limitations in adaptive

functioning; (3) the onset of which occurs before age of 18.[1] *Briseno*, 135 S.W.3d at 7.

In determining whether an offender meets the second prong—impaired adaptive functioning—the Texas courts have "cited with approval" the 1992 edition of the AAMR's grouping of adaptive behavior into three areas: conceptual skills, social skills, and practical skills. *Moore*, 470 S.W.3d at 488 (citing *Ex parte Hearn*, 310 S.W.3d 424, 428 (Tex. Crim. App. 2010)). Additionally, the Texas courts have recognized the APA's position, expressed in the APA's *Diagnostic and Statistical Manual* (4th ed. text revision 2000) ("DSM-IV-TR"), "that for purposes of clinical diagnosis, a 'significant limitation' is defined by a score of at least two standard deviations below" the mean in an adaptive behavior skill area or the overall score for all three areas. *Id.* (citing *Hearn*, 310 S.W.3d at 428).

Petitioner and his *Amici* cannot contend that Texas' definition of intellectual disability and conception of adaptive functioning is not "informed by the medical community's diagnostic framework." *Hall*, 134 S. Ct. at 2000. Indeed, in developing its standards and

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[1] Nearly every State—as well as past and present iterations of the professional associations' publications—uses this basic three-prong definition. *See* App. A, C. This brief includes Appendices consisting of charts listing State, AAIDD, and APA definitions of intellectual disability and of impairment or deficits in adaptive functioning. Citations of "App.__" refer to these Appendices. The chart does not include those twenty States that do not currently provide for capital punishment. Since *Atkins'* limitation on which offenders may be subjected to the death penalty is immaterial in those States, they would have no reason to espouse a view regarding how such offenders should be identified. *See Hall*, 134 S. Ct. at 2004 (Alito, J., dissenting).

framework for determining intellectual disability, the Texas courts drew from the very same clinical definitions to which this Court looked in *Atkins*. *See* 536 U.S. at 308 n.3.

Petitioner, and several of his *amici* nevertheless maintain that Texas' approach to determining intellectual disability is unconstitutional. To that end, they focus on the holding below that the trial court erred by ignoring Texas' established framework for assessing intellectual disability and instead applying the AAIDD's most recent definition. *See Moore*, 470 S.W.3d at 486. And in doing so, The Constitution Project frames the analysis as whether there is a national consensus "forbid[ding] … the use of modern medical standards in *Atkins* cases." (Br. *Amicus Curiae* of The Constitution Project at 10.)

But The Constitution Project mischaracterizes the Texas court's conclusion and thus misses the relevant question. The court below did not "forbid" the use of the most recent clinical definitions. Instead, it required the lower courts to apply Texas' established legal standards for assessing claims of intellectual disability.

The relevant inquiry, therefore, is whether there is a national consensus among the States to amend their intellectual disability statutes to adopt the most recently published clinical definitions and criteria. Answering that question demonstrates that the Eighth Amendment challenge to Texas' intellectual disability criteria fails because the States have overwhelmingly retained their intellectual disability standards adopted before or shortly after *Atkins* was decided and have not rushed to amend them to strictly conform to the newest AAIDD manual or DSM.

B. There is no national consensus to adopt the latest clinical definitions of intellectual disability.

As reaffirmed once again in *Hall*, in enforcing the Eighth Amendment's ban on "cruel and unusual punishments," this Court "looks to the 'evolving standards of decency that mark the progress of a maturing society.'" 134 S. Ct. at 1992 (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)). And to discern the nation's evolving moral standards, the Court has long recognized that the laws enacted by the State legislatures provide the "clearest and most reliable objective evidence of contemporary values." *Penry v. Lynaugh*, 492 U.S. 302, 331 (1989). That is true because "in a democratic society legislatures, not courts, are constituted to respond to the will and consequently the moral values of the people." *Gregg v. Georgia*, 428 U.S. 153, 175–76 (1976) (opinion of Justices Stewart, Powell, and Stewart) (quotation omitted). Consistent with this framework, when the Court analyzed whether the Eighth Amendment barred the execution of intellectually disabled offenders in *Atkins*, and whether assessment of IQ required taking into account the standard error of measurement in *Hall*, it examined whether the actions of the States reflected a national consensus on those issues. *Hall*, 134 S. Ct. at 1996–98; *Atkins*, 536 U.S. at 313–18.

In the view of The Constitution Project, Texas is an "outlier" in "forbidding the use of modern medical standards." (Br. of The Constitution Project at 13.) Despite this bold contention, The Constitution Project makes no meaningful attempt (and Petitioner makes no attempt at all) to establish that Texas is the only

State not to have joined in some "national consensus" to adopt the medical community's latest prescriptions for its legal standard to determine intellectual disability. Nor could it: there is no such national consensus and Texas is not an "outlier" among the States.

Viewed correctly, *i.e.*, focusing on Texas' use of intellectual disability criteria consistent with those relied upon by this Court in *Atkins*, it becomes clear that Texas is not an "outlier," but rather stands among the overwhelming majority of death penalty States that have declined to adopt medical associations' latest criteria for diagnosing intellectual disability. Despite mental health associations making changes to their definitions and standards regarding intellectual disability in recent years, the States by and large have retained their legal definitions adopted before or shortly after this Court decided *Atkins*. And because there is no national consensus against Texas' approach, the "clearest and most reliable objective evidence of contemporary values" fails to support any claim that it is unconstitutional. *Hall*, 134 S. Ct. at 2002 (quoting *Atkins*, 536 U.S. at 312).

If The Constitution Project were correct that Texas is an outlier because it has not adopted these professional associations' most recent diagnostic definitions, one would expect the majority of the States to have adopted either the AAIDD's or the APA's (or both organizations') latest clinical definitions and standards for diagnosing intellectual disability. But that is not the case.

First, by using the term "significantly subaverage" or "significant subaverage" intellectual functioning, an

overwhelming majority of twenty-four States with capital punishment reflect the AAMR 9th ed.[2] and DSM-IV-TR definitions of intellectual disability, both of which this Court referred to in *Atkins*.[3] A.R.S. § 13-753(K); ARK. CODE § 5-4-618(A)(1); COLO. REV. STAT. § 18-1.3-1101(2); FLA. STAT. § 921.137(1); GA. CODE § 17-7-131(a)(3); IDAHO CODE § 19-2515A(1); IND. CODE §§ 35-36-9-2, 35-36-9-3(c); KAN. STAT. §§ 21-6622; KY. REV. STAT. § 532.130(2); MO. REV. STAT. § 565.030(6); NEV. REV. STAT. § 174.098(7); N.C. GEN. STAT. § 15A-2005(a)(1)(a); OKLA. STAT. TIT. 21, § 701.10b(A)(1), (B); S.C. CODE § 16-3-20(C)(b)(10); S.D. CODIFIED LAWS § 23A-27A-26.2; TENN. CODE § 39-13-203(a); UTAH CODE § 77-15A-102; VA. CODE § 19.2-264.3:1.1(A); WASH. REV. CODE § 10.95.030(2)(a); WYO. STAT. § 8-1-102(a)(xiii); *In re Hawthorne*, 105 P.3d 552, 554 (Cal. 2005); *State v. Lott*, 779 N.E.2d 1011, 1014 (Ohio 2002); *Commonwealth v. Bracey*, 117 A.3d 270, 274 (Pa. 2015); *Ex parte Briseno*, 135 S.W.3d 1, 7–8 (Tex. Ct. Crim. App. 2004); *see also Atkins*, 536 U.S. at 308 n.3 (quoting AAMR 9th ed. and DSM-IV-TR).

Next, the variety of approaches utilized by the States to define impairments or deficits in adaptive functioning similarly demonstrate the lack of any

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[2] American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* (9th ed. 1992).

[3] While both the AAMR 9th ed. and the DSM-IV-TR stated that intellectual disability included "significantly subaverage" intellectual functioning, both publications omitted that language in subsequent editions. For example, the AAMR 10th ed. and AAIDD 11th ed. use the term "significant limitations" in intellectual functioning and the DSM-5 uses the term intellectual "deficits." *See* Appx. C.

national consensus adopting the latest in clinical and diagnostic criteria. When *Atkins* was decided, both the AAMR 9th ed. and the DSM-IV-TR defined impaired adaptive functioning as limitations in two or more of the following "skill areas": communication, self-care, home living, social skills, use of community resources, self-direction, health and safety, functional academics, leisure, and work. *See* AAMR 9th ed. at 5, 38; DSM-IV-TR at 41; *see also Atkins*, 536 U.S. at 308 n.3. But in its subsequent edition, published shortly after *Atkins*, the AAMR significantly changed its adaptive functioning definition to the following: "performance that is at least two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical, or (b) an overall score on a standardized measure of conceptual, social, and practical skills."[4] American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 13, 14 (10th ed. 2002) ("AAMR 10th ed."). The APA made a similar wholesale change to its definition of adaptive functioning, requiring "at least one domain of adaptive functioning—conceptual, social or practical—is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, at work, at home, or in the community." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 41 (5th ed. 2013) ("DSM-5").

Despite these significant changes, the most common approach, applied by twelve death penalty States,

[4] The AAIDD retained this definition in its 11th edition. American Association on Intellectual and Developmental Disabilities 43 (11th ed. 2010) ("AAIDD 11th ed.").

continues to employ the AAMR 9th ed. and DSM-IV-TR definition of adaptive functioning. *See* IDAHO CODE § 19-2515A(1); MO. REV. STAT. § 565.030(6); N.C. GEN. STAT. § 15A-2005(A)(1)(B); OKLA. STAT. TIT. 21, § 701.10b(A)(2); *Sasser v. Hobbs*, 735 F.3d 833, 848 (8th Cir. 2013) (Arkansas). *Lane v. State*, 169 So. 3d 1076, 1088–89 (Ala. Crim. App. 2013); *Hawthorne*, 105 P.3d at 556–57; *Hodges v. State*, 55 So.3d 515, 534 (Fla. 2010); *Bowling v. Commonwealth*, 163 S.W.3d 361, 367–68 (Ky. 2005) (quoting *Atkins*); *Lott*, 779 N.E.2d at 1014; *State v. Pruitt*, 415 S.W.3d 180, 204 (Tenn. 2013); *Ex parte Briseno*, 135 S.W.3d 1, 7 (Tex. Crim. App. 2004).

Furthermore, two States use a definition taken from earlier AAIDD and APA standards.[5] *See* A.R.S. § 13–753(K)(1) ("the effectiveness or degree to which the defendant meets the standards of personal independence and social responsibility expected of the defendant's age and cultural group"); WASH. REV. CODE § 10.95.030(2)(d) (same); *see also* American Association on Mental Deficiency, *Classification in Mental Retardation* (8th ed. 1983) ("Deficits in adaptive behavior are defined as significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that are expected for his or her age level and cultural group … ."); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 32 (3d ed. revised 1987) ("Concurrent deficits or impairments in adaptive functioning, i.e.,

[5] Although the DSM-IV-TR and DSM-5 use a different definition of adaptive functioning, the DSM-5's explanation of adaptive behavior includes language similar to that found in Arizona's and Washington's statutes. *See* DSM-5 at 33.

the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group in areas such as social skills and responsibility, communication, daily living skills, personal independence, and self-sufficiency.").

The remaining States use several different approaches to determine impairments or deficits in adaptive functioning. Indiana and Nevada appear to employ the AAMR 10th ed. and DSM-IV-TR definitions of adaptive functioning, and Virginia uses the AAMR 10th ed. standard. *See* VA. CODE § 19.2-264.3:1.1(A), (B)(2); *Pruitt v. State*, 834 N.E.2d 90, 109–10 (Ind. 2005) (characterizing these standards as a "safe harbor" and noting that statutory standard is "very similar" to AAMR 10th ed.); *Ybarra v. States*, 247 P.3d 269, 274 (Nev. 2011) (referring to AAMR 10th ed. and DSM-IV-TR definitions as providing "useful guidance in applying" statute).

Seven States—Colorado, Georgia, Montana, New Hampshire, South Carolina, South Dakota, and Wyoming—have not defined what constitutes sufficient impairment or deficits in adaptive functioning. Kansas alone does not require any showing of impaired adaptive functioning to establish intellectual disability. Kan. Stat. §§ 21-6622; *State v. Maestas*, 316 P.3d 724, 736–37 (Kan. 2014). And Utah focuses on whether the defendant has significant deficiencies in adaptive functioning "primarily in the areas of reasoning or impulse control." UTAH CODE § 77-15a-102; *see also Atkins*, 536 U.S. at 318 (intellectually disabled have diminished capacity "to engage in logical reasoning, to control impulses"). None of these varied approaches applies the newest AAIDD or APA standards.

Finally, as noted by Respondent (Resp. Br. at 25–26), only four States have adopted either the AAIDD's or the APA's latest clinical standards to define intellectual disability and, therefore, to determine what constitutes sufficiently impaired adaptive functioning. LA. CODE CRIM. P. ART. 905.5.1; *Chase v. State*, 171 So.3d 463, 471 (Miss. 2015); *State v. Agee*, 364 P.3d 971, 989–90 (Or. 2015); *Bracey*, 117 A.3d 270, 274 (Pa. 2015).[6] Four States out of fifty (or out of thirty with capital punishment) is far from a national consensus. Just the opposite. The States' varied approaches to determining impairment or deficits in adaptive functioning shows that, if anything, there is a national consensus *against* adopting the medical associations' latest clinical standards. Texas is not an outlier, but part of a near unanimous majority in declining to adopt the newest clinical criteria published by professional associations.

To be sure, the States' definitions of intellectual disability and standards for determining impaired adaptive functioning do what this Court required in *Atkins* and *Hall*: they are "informed by the views of medical experts." *See Hall*, 134 S. Ct. at 2000. Indeed, the standards reviewed herein are based on such views. *See* App. A–C; *see also* Resp. Br. at Appendix. But there simply is no national consensus to strictly conform to the most recent medical standards contrary to Texas' approach to determining intellectual disability. In the absence of any such consensus, there is no basis to

[6] Notably, Pennsylvania has not wholly adopted both the AAIDD's and APA's latest clinical standards. Instead, it approved the use of the AAIDD 11th ed. and the DSM-IV-TR standard in a case where the evidentiary hearing occurred before publication of the DSM-5. *See Bracey*, 117 A.3d at 274; *see also* Resp. Br. at 26–27.

conclude that Texas' use of an intellectual disability framework that does not strictly adhere to the latest clinical criteria conflicts with society's standards of decency. *See Penry*, 492 U.S. at 335. Thus, the "clearest and most reliable objective evidence of contemporary values" fails to support any claim that Texas' approach to determining intellectual disability is unconstitutional. *Hall*, 134 S. Ct. at 2002 (quoting *Atkins*, 536 U.S. at 312).

II. *ATKINS* AND *HALL* DO NOT REQUIRE THE STATES TO CEDE THEIR ROLE IN DEFINING INTELLECTUAL DISABILITY AND TO STRICTLY CONFORM TO MENTAL HEALTH ORGANIZATIONS' MOST RECENT DIAGNOSTIC STANDARDS.

A. This Court has never required the States to relinquish authority for creating standards governing important legal determinations to private professional associations.

Petitioner and his *Amici* view *Atkins* and *Hall* as prohibiting the States from playing any substantive role in creating standards for the determination of intellectual disability in capital cases. Instead, their view would limit the States to the purely administrative task of amending their laws to strictly conform to the most "current medical standards." *See, e.g.,* Pet. Br. at 30; Br. *Amici Curiae* of APA *et al.* at 14; Br. *Amici Curiae* of AAIDD *et al.* at 4. Petitioner premises this argument on the fact that, when describing mental retardation in *Atkins*, and when considering the assessment of IQ scores in *Hall*, the Court cited definitions provided by the AAMR and the APA. Pet. Br. at 27–30.

Of course, in both *Atkins* and *Hall* the Court cited and referred to clinical definitions of intellectual disability. *Hall*, 134 S. Ct. at 1994, 1995, 1998–99, 2001; *Atkins*, 536 U.S. at 308 n.3, 317 n.22. But reference to clinical definitions of intellectual disability hardly equates to adoption of the latest APA and AAIDD diagnostic criteria as the Eighth Amendment standard. Nothing in those cases suggests that the Court stripped the States of their authority to create appropriate standards and outsourced to private professional associations sole responsibility for setting the constitutional standard for implementing the Eighth Amendment restriction against executing intellectually disabled offenders.

Just the opposite is true. In *Atkins*, the Court expressly left to the States the "task of developing appropriate ways to enforce the constitutional restriction upon [their] execution of sentences." 536 U.S. at 317. The Court observed that there might be "serious disagreement in determining which offenders are in fact retarded. . . . Not all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus." *Id.* And it understood that the existing statutory definitions of intellectual disability enacted by the States were "not identical" and only "generally conform[ed]" to the clinical definitions the Court cited. *Id*. n.22. Nowhere in the decision did the Court even suggest, much less announce, that it was relegating the States to the rote task of adopting clinical standards verbatim in their statutes and updating their laws each time the mental health associations change their criteria. If any doubt remained, the Court reaffirmed seven years later that

Atkins "did not provide definitive procedural or substantive guides for determining when a person" is intellectually disabled. *Bobby v. Bies*, 556 U.S. 825, 831 (2009).

Nor did *Hall* impose any such requirement. There, the Court held that a Florida statute requiring an IQ test score of 70 or below, without considering margin of error, before a defendant was permitted to present additional evidence of intellectual disability violated the Eighth Amendment. *Hall*, 134 S. Ct. at 1991–92. The Court found the strict IQ cutoff unconstitutional because it disregarded established medical practice *and* went against a trend in a majority of States toward accounting for the standard error of measurement in IQ testing. *Id.* at 1995, 1998.

Hall does not support the argument that the States are constitutionally mandated to strictly conform to the newest clinical definitions for their intellectual disability determinations. Although the Court did not grant the States "complete autonomy to define intellectual disability as they wished," *Id.* at 1999, it nonetheless reaffirmed that "[t]he legal determination of intellectual disability is distinct from a medical diagnosis." *Id.* at 2000.

In support of his view, Petitioner relies on the Court's statements in *Hall* that "*Atkins* did not give the States unfettered discretion to define the full scope of the constitutional protection" or "complete autonomy to define intellectual disability as they wished." Pet. Br. at 29 (quoting *Hall*, 134 S. Ct. at 1998, 1999). That may be true, but neither did the Court hand private professional organizations the keys to constitutional standards by forcing the States to unquestioningly

adopt the APA and AAIDD definitions of intellectual disability and amend their laws every time those organizations tweak or adjust their clinical criteria. To do so would have removed a key function in the administration of criminal justice from its proper authority, the States, and placed it in the hands of "a small professional elite" that may be motivated to expand the definition of intellectual disability for the sole purpose of limiting the States' ability to impose the death penalty. *See Hall*, 134 S. Ct. at 2005 (Alito, J., dissenting).

To the contrary, *Hall* simply acknowledged that the legal standards for determining intellectual disability are "informed by the medical community's diagnostic framework." *Id.* And in reaching its ultimate conclusion about the IQ cutoff at issue, the Court itself did not simply defer to the APA and AAIDD, but rather "express[ed] its own independent determination reached in light of the instruction found in" the medical literature *as well as* legislative policies of the States. *Id.* at 1993.

Furthermore, the conclusion that this Court has not required strict adoption of clinical criteria is firmly supported by the Circuit Courts of Appeal, which have uniformly concluded that the Eighth Amendment does not impose on the States any specific definition of intellectual disability or requirement of strict adherence to clinical standards. *See, e.g., Ledford v. Warden, Ga. Diagnostic & Classification Prison*, 818 F.3d 600, 637–38 (11th Cir. 2016) ("[D]istrict courts do not need to revisit rulings every time the APA publishes a revised DSM or the AAIDD publishes a new article. . . . While medical literature informs a

court's legal analysis, it does not control it."); *Moormann v. Schriro,* 672 F.3d 644, 648 (9th Cir. 2012) ("The Supreme Court in *Atkins* did not define mental retardation as a matter of federal law. With respect to mental retardation ... the Supreme Court left to the states 'the task of developing appropriate ways to enforce the constitutional restriction upon [their] execution of sentences.'" (alteration in original)) (quoting *Atkins,* 536 U.S. at 317); *Ochoa v. Workman*, 669 F.3d 1130, 1137 (10th Cir. 2012) (*Atkins* did not mandate any specific substantive criteria for assessing intellectual disability claims); *Chester v. Thaler*, 666 F.3d 340 (5th Cir. 2011) ("*Atkins* clearly did not hold … that states must employ the AAMR or APA definitions of mental retardation, let alone that they must employ the same underlying clinical analysis that the AAMR and APA use to determine which patients meet each prong of those organizations' definitions."); *Hill v. Humphrey,* 662 F.3d 1335, 1351–52 (11th Cir. 2011) (en banc) ("*Atkins* did not bestow a substantive Eighth Amendment right to a fixed and rigid definition of 'mentally retarded persons.' Indeed, various states use different definitions of intellectual functioning (some draw the line at an IQ of 75 or below, some at 70 or below, others at 65 or below) and consider different factors in assessing adaptive functioning." (footnote omitted)); *Larry v. Branker*, 552 F.3d 356, 369 (4th Cir. 2009) (rejecting argument that Atkins "requires every state to employ a particular 'clinical' approach to measuring a defendant's adaptive skills": "*Atkins* does not require states to use a specific method of determining whether a defendant is mentally retarded; rather, as noted above, *Atkins* expressly left to the states the task of defining mental retardation."); *Allen*

v. Buss, 558 F.3d 657, 665 (7th Cir. 2009) ("[T]he Supreme Court in *Atkins* did *not* establish a national standard for mental retardation but expressly left to the states the task of defining mental retardation." (emphasis in original)).

By looking to medical criteria for guidance, but stopping far short of requiring their strict adoption as constitutional standards, *Atkins* and *Hall* are consistent with this Court's precedent in related contexts that "the science of psychiatry ... informs but does not control ultimate legal determinations." *Kansas v. Crane*, 534 U.S. 407, 413 (2002). In those other contexts, as here, the Court has "traditionally left to legislators the task of defining terms of a medical nature that have legal significance." *Kansas v. Hendricks*, 521 U.S. 346, 359 (1997) (noting that legal definitions of "insanity" and "competency" "vary substantially from their psychiatric counterparts"); *see also Crane*, 534 U.S. at 407–08 ("psychiatry … is an ever-advancing science, whose distinctions do not seek precisely to mirror those of the law"). As a result, "[l]egal definitions … which must 'take into account such issues as individual responsibility … and competency' need not mirror those advanced by the medical profession." *Hendricks*, 521 U.S. at 359 (quoting the DSM-IV).

It is not only in relation to medical determinations that the Court has declined to adopt private associations' standards or criteria as constitutional requirements. In an analogous context, this Court has declined to cede control over the standard of reasonable attorney performance under the Sixth Amendment to the American Bar Association ("ABA"), a private

professional association like the APA and AAIDD. Rather, the Court has recognized that while the ABA's guidelines for counsel might serve as "guides to determining what is reasonable, … *they are only guides*." *Wiggins v. Smith*, 539 U.S. 510, 546–47 (2003) (emphasis in original) (quoting *Strickland v. Washington*, 466 U.S. 668, 688 (1984)); s*ee also Bobby v. Van Hook*, 558 U.S. 4, 14 (2009) (Alito, J., concurring) ("It is the responsibility of the courts to determine the nature of the work that a defense attorney must do in a capital case in order to meet the obligations imposed by the Constitution, and I see no reason why the ABA Guidelines should be given a privileged position in making that determination."). The Court has never suggested that the ABA is responsible for setting the Sixth Amendment standard of reasonable performance by defense counsel; nor would it be appropriate to do so. Similarly here, although the Court acknowledged in *Atkins* and *Hall* that the legal determination of intellectual disability is "informed" by the standards used by professional medical associations, it has never ceded control over the standards to those associations, nor should it.

Instead, recognizing the distinctions between intellectual disability's legal determination and medical diagnosis, and respecting the States' authority over the administration of criminal justice, the Court has left to the States the task of creating substantive criteria for identifying those offenders whose "disabilities in areas of reasoning, judgment, and control of their impulses" prevent them from acting "with the level of moral culpability that characterizes the most serious adult criminal conduct." *Atkins*, 536 U.S. at 307. In sum, the States retain their prerogative

under *Atkins* and *Hall* to develop both legal processes and substantive legal standards—which are not constitutionally required to strictly conform to recommended clinical practices—for determining when an otherwise death-eligible offender is intellectually disabled.

B. This Court should not hand over responsibility for creating the substantive legal standards for determining intellectual disability to private professional associations.

It is for good reason that this Court has never required the States to strictly conform to the medical community's clinical criteria for legal determinations or adopted wholesale private associations' guidelines as constitutional standards. First, consistent with this Court's recognition of the differences between medical diagnoses and related legal determinations, the APA itself suggests that its clinical criteria should not be adopted wholesale as legal standards, warning of the "imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis." DSM-5 at 25. It specifically states that "[i]n most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual disability … *does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard . . . .*" *Id.* (emphasis added). And, particularly relevant to the issue of moral culpability and intellectual disability, the APA cautions that "additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the

individual's functional impairments and how these impairments affect the particular abilities in question." *Id.*

Second, the Court should not entrust the creation of constitutional standards central to the administration of criminal justice to professional organizations that may have agendas at odds with the States' interest in the orderly administration of their criminal justice systems. For example, the APA has expressed institutional hostility to the death penalty, a punishment that the laws of thirty States and the United States deem valid and proper, by advocating for a nationwide moratorium on its use. APA Official Actions, *Position Statement on Moratorium on Capital Punishment in the United States*, December 2014, available at http://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2014-Moratorium-Capital-Punishment.pdf. This policy agenda is not only contrary to those States with capital punishment, but also to *Atkins* itself, which conceived of a narrow exception to eligibility for the death penalty for those intellectually disabled "offenders about whom there is a national consensus." 536 U.S. at 317.

Third, tying constitutional standards to the views of professional organizations would likely prove impractical. The current diagnostic criteria utilized by professional associations often change,[7] which would require frequent statutory amendments, and surely additional litigation, with each adjustment to clinical standards. And as the APA admits, "[t]he AAIDD Manual and DSM-5 definitions of intellectual disability

[7] *See* App. C.

differ in some particulars." Br. of APA at 7 n.3. If the views of professional organizations set the constitutional standard, but those views differ, how are the States, or the courts for that matter, to decide which standard the Eighth Amendment requires? *Cf. Clark v. Arizona*, 548 U.S. 735, 753 (2006) ("There being such fodder for reasonable debate about what the cognate legal and medical tests should be, due process imposes no single canonical formulation of legal insanity.").

Finally, as this Court recently acknowledged, "[t]he legal determination of intellectual disability is distinct from a medical diagnosis." *Hall*, 134 S. Ct. at 2000. For purposes of capital punishment, intellectual disability is important due to the diminished moral culpability resulting from deficiencies in understanding information, communication, learning, reasoning, and impulse control, and an impaired understanding of execution as a penalty. *See Atkins*, 536 U.S. at 318, 320. Consequently, in making a legal determination of intellectual disability, "additional information is usually required beyond" a clinical diagnosis, "which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question." DSM-5 at 25.

In sum, it is the prerogative and responsibility of the States, not private professional associations, to formulate the substantive criteria for determining intellectual disability in capital cases. Medical standards provide a guide for the States in doing so, but "they are only guides." *Cf. Wiggins*, 539 U.S. at 546–47 (emphasis omitted). The States must not be relegated to the administrative task of conforming their

statutes to the professional associations' latest criteria, but rather must retain the crucial authority to develop substantive standards for the administration of their criminal justice systems.

CONCLUSION

The Court should affirm the decision of the Texas Court of Criminal Appeals.

Respectfully submitted.

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APPENDIX

APPENDIX

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APPENDIX A

State Intellectual Disability Definitions	
AL	Applies clinical standards considered in *Atkins*: "[T]he *Atkins* Court discussed clinical definitions of mental retardation and concluded that these definitions require not only subaverage intellectual functioning, but also significant limitations in adaptive skills such as communication, self-care, and self-direction that became manifest before age 18." *Lane v. State*, 169 So. 3d 1076, 1088–89 (Ala. Crim. App. 2013) (quotation omitted).
AZ	A condition based on a mental deficit that involves significantly subaverage general intellectual functioning, existing concurrently with significant impairment in adaptive behavior, where the onset of the foregoing conditions occurred before the defendant reached the age of eighteen. A.R.S. § 13-753(K).
AR	Significantly subaverage general intellectual functioning accompanied by a significant deficit or impairment in adaptive functioning manifest in the developmental period, but no later than age eighteen (18) years of age; and a deficit in adaptive behavior. ARK. CODE § 5-4-618(a)(1).
CA	"[T]he condition of significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before the age of 18." *In re Hawthorne*, 105 P.3d 552, 554 (Cal. 2005).

CO	Any defendant with significantly subaverage general intellectual functioning existing concurrently with substantial deficits in adaptive behavior and manifested and documented during the developmental period. The requirement for documentation may be excused by the court upon a finding that extraordinary circumstances exist. COLO. REV. STAT. § 18-1.3-1101(2).
FL	Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the period from conception to age 18. FLA. STAT. § 921.137(1).
GA	Having significantly subaverage general intellectual functioning resulting in or associated with impairments in adaptive behavior which manifested during the developmental period. GA. CODE § 17-7-131(a)(3).
ID	Significantly subaverage general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two (2) of the following skill areas: communication, self-care, home living, social or interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. The onset of significant subaverage general intelligence functioning and significant limitations in adaptive functioning must occur before age eighteen (18) years. IDAHO CODE § 19-2515A(1).

IN	An individual who, before becoming twenty-two (22) years of age, manifests: (1) significantly subaverage intellectual functioning; and (2) substantial impairment of adaptive behavior. IND. CODE §§ 35-36-9-2, 35-36-9-3(c).
KS	Having significantly subaverage general intellectual functioning, as defined by K.S.A. 76-12b01, and amendments thereto, to an extent which substantially impairs one's capacity to appreciate the criminality of one's conduct or to conform one's conduct to the requirements of law. KAN. STAT. §§ 21-6622.
KY	Significant subaverage intellectual functioning existing concurrently with substantial deficits in adaptive behavior and manifested during the developmental period KY. REV. STAT. § 532.130(2).
LA	A disability characterized by all of the following deficits, the onset of which must occur during the developmental period: (a) Deficits in intellectual functions such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing. (b) Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility; and that, without ongoing support, limit functioning in one or more activities of daily life including, without limitation,

	communication, social participation, and independent living, across multiple environments such as home, school, work, and community. LA. CODE CRIM. P. ART. 905.5.1.
MS	Adopting AAIDD 11th and DSM-5 definitions of intellectual disability. *Chase v. State*, 171 So.3d 463, 471 (Miss. 2015).
MO	A condition involving substantial limitations in general functioning characterized by significantly subaverage intellectual functioning with continual extensive related deficits and limitations in two or more adaptive behaviors such as communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, which conditions are manifested and documented before eighteen years of age. MO. REV. STAT. § 565.030(6).
MT	No definition.
NV	Significant subaverage general intellectual functioning which exists concurrently with deficits in adaptive behavior and manifested during the developmental period. NEV. REV. STAT. § 174.098(7).
NH	No definition.[1]

[1] This chart does not include intellectual disability statutes enacted for another purpose that have not been adopted for or applied to *Atkins* claims.

NC	A condition marked by significantly subaverage general intellectual functioning, existing concurrently with significant limitations in adaptive functioning, both of which were manifested before the age of 18. N.C. GEN. STAT. § 15A-2005(a)(1)(a).
OH	Significantly subaverage intellectual functioning, significant limitations in two or more adaptive skills, such as communication, self-care, and self-direction, and onset before the age of 18. *State v. Lott*, 779 N.E.2d 1011, 1014 (Ohio 2002) (citing *Atkins*, AAMR 10th, and DSM-IV-TR).
OK	Significantly subaverage general intellectual functioning, existing concurrently with significant limitations in adaptive functioning, which manifested before age 18. OKLA. STAT. TIT. 21, § 701.10b(A)(1), (B).
OR	Adopting DSM-5 criteria. *State v. Agee*, 364 P.3d 971, 989–90 (Or. 2015).
PA	Significantly subaverage intellectual functioning, significant adaptive deficits, and onset before age 18. *Commonwealth v. Bracey*, 117 A.3d 270, 274 (Pa. 2015).
SC	Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. S.C. CODE § 16-3-20(C)(b)(10).

SD	Significant subaverage general intellectual functioning existing concurrently with substantial related deficits in applicable adaptive skill areas. S.D. CODIFIED LAWS § 23A-27A-26.2.
TN	Significantly subaverage general intellectual functioning as evidenced by a functional intelligence quotient (I.Q.) of seventy (70) or below; (2) Deficits in adaptive behavior; and (3) The intellectual disability must have been manifested during the developmental period, or by eighteen (18) years of age. TENN. CODE § 39-13-203(a).
TX	Significantly subaverage general intellectual functioning; accompanied by related limitations in adaptive functioning; the onset of which occurs prior to the age of 18. *Ex parte Briseño*, 135 S.W.3d 1, 7–8 (Tex. Crim. App. 2004) (citing AAMR 9th and Tex. Health & Safety Code § 591.003(7-a)).
UT	Significant subaverage general intellectual functioning that results in and exists concurrently with significant deficiencies in adaptive functioning that exist primarily in the areas of reasoning or impulse control, or in both of these areas, both of which are manifested before age 22. UTAH CODE § 77-15a-102.

VA	A disability, originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social and practical adaptive skills. VA. CODE § 19.2-264.3:1.1(A).
WA	Significantly subaverage general intellectual functioning; (ii) existing concurrently with deficits in adaptive behavior; and (iii) both significantly subaverage general intellectual functioning and deficits in adaptive behavior were manifested during the developmental period. WASH. REV. CODE § 10.95.030(2)(a).
WY	Significantly subaverage general intellectual functioning with concurrent deficits in adaptive behavior manifested during the developmental period. WYO. STAT. § 8-1-102(a)(xiii).

APPENDIX B

State Adaptive Functioning/ Behavior Standards	
AL	"[S]ignificant limitations in adaptive skills such as communication, self-care, and self-direction." *Lane v. State*, 169 So. 3d 1076, 1088–89 (Ala. Crim. App. 2013).
AZ	The effectiveness or degree to which the defendant meets the standards of personal independence and social responsibility expected of the defendant's age and cultural group. A.R.S. § 13-753(K)(1).
AR	More than one significant adaptive limitation in the DSM-IV-TR adaptive skill areas. *Sasser v. Hobbs*, 735 F.3d 833, 848 (8th Cir. 2013).
CA	Applies AAMR 9th and/or DSM-IV-TR definition. *In re Hawthorne*, 105 P.3d 552, 556–57 (Cal. 2005).
CO	No definition.
FL	The effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community. *Id.* To be diagnosed as mentally retarded, a defendant must show significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, and work. *Hodges v. State*, 55 So.3d 515, 534 (Fla. 2010) (citing *Atkins*).

GA	No definition.
ID	Significant limitations in adaptive functioning in at least two (2) of the following skill areas: communication, self-care, home living, social or interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. IDAHO CODE § 19-2515A(1).
IN	Declining to adopt DSM-IV-TR and AAMR 10th standards but characterizing them as a "safe harbor." *Pruitt v. State*, 834 N.E.2d 90, 109–10 (Ind. 2005).
KS	No showing of impaired adaptive behavior required. See *State v. Maestas*, 316 P.3d 724, 736–37 (Kan. 2014).
KY	Quoting *Atkins'* references to AAMR 9th ed. and DSM-IV-TR definitions. *Bowling v. Commonwealth*, 163 S.W.3d 361, 367–68 (Ky. 2005).
LA	Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility; and that, without ongoing support, limit functioning in one or more activities of daily life including, without limitation, communication, social participation, and independent living, across multiple environments such as home, school, work, and community. LA. CODE CRIM. P. ART. 905.5.1.
MS	Adopting AAIDD 11th and DSM-5 definitions of intellectual disability. *Chase v. State*, 171 So.3d 463, 471 (Miss. 2015).

MO	Related deficits and limitations in two or more adaptive behaviors such as communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. MO. REV. STAT. § 565.030(6).
MT	No definition.
NV	Referring to AAMR 10th and DSM-IV-TR as "useful guidance in applying" the statutory definition. *Ybarra v. State*, 247 P.3d 269, 274 (Nev. 2011).
NH	No definition.
NC	Significant limitations in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure skills and work skills. N.C. GEN. STAT. § 15A-2005(a)(1)(b). Accepted clinical standards for diagnosing significant limitations in intellectual functioning and adaptive behavior shall be applied in the determination of intellectual disability. *Id.* § 15A-2005(a)(2).
OH	Significant limitations in two or more adaptive skills, such as communication, self-care, and self-direction. *State v. Lott*, 779 N.E.2d 1011, 1014 (Ohio 2002).

OK	Significant limitations in two or more of the following adaptive skill areas; communication, self-care, home living, social skills, community use, self-direction, health, safety, functional academics, leisure skills and work skills. OKLA. STAT. TIT. 21, § 701.10b(A)(2).
OR	Adopting DSM-5 criteria. *State v. Agee*, 364 P.3d 971, 989–90 (Or. 2015).
PA	Citing AAIDD 11th and DSM-IV-TR definitions. *Commonwealth v. Bracey*, 117 A.3d 270, 274 (Pa. 2015).
SC	No definition.
SD	No definition.
TN	"Significant limitations in at least two of the following basic skills: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety." *State v. Pruitt*, 415 S.W.3d 180, 204 (Tenn. 2013) (quotation omitted).
TX	Citing with approval AAMR 9th edition definition. *Ex parte Briseno*, 135 S.W.3d 1, 7–8 (Tex. Crim. App. 2004).
UT	Deficiencies in adaptive functioning that exist primarily in the areas of reasoning or impulse control, or in both of these areas. UTAH CODE § 77-15a-102.
VA	Significant limitations in adaptive behavior as expressed in conceptual, social and practical adaptive skills. VA. CODE § 19.2-264.3:1.1(A).

WA	The effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for his or her age. WASH. REV. CODE § 10.95.030(2)(d).
WY	No definition.

APPENDIX C

AAIDD and APA Intellectual Disability Definitions	
AAMD 8th ed.	Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.[1]
AAMR 9th ed.	Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in . . . adaptive skill areas . . . . Mental retardation manifests before age 18.[2]
AAMR 10th ed.	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.[3]

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[1] American Association on Mental Deficiency, *Classification in Mental Retardation* 11 (8th ed. 1983).

[2] American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 5 (9th ed. 1992).

[3] American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 39 (10th ed. 2002).

AAIDD 11th ed.	Intellectual disability is 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 are 18.[4]
DSM-III-R	The essential features of this disorder are: (1) significantly subaverage general intellectual functioning, accompanied by (2) significant deficits or impairments in adaptive functioning, with (3) onset before the age of 18.[5]
DSM-IV-TR	The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning … (Criterion B). The onset must occur before age 18 years (Criterion C).[6]

[4] American Association on Intellectual and Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Supports* 5 (11th ed. 2010).

[5] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 28 (3d ed. revised 1987).

[6] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* 41 (4th ed. text revision 2000).

DSM-5	Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.[7]

[7] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 33 (5th ed. 2013). Although the DSM-5, unlike the DSM-IV-TR, no longer includes a particular IQ score in its diagnostic criteria, it states: "Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points." *Id*. at 37.

AAIDD and APA Adaptive Functioning Standards	
AAMD 8th ed.	Deficits in adaptive behavior are defined as significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that are expected for his or her age level and cultural group, as determined by clinical assessment and, usually, standardized scales.[8]
AAMR 9th ed.	Limitations in two or more of the following applicable adaptive skills areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.[9]
AAMR 10th ed.	Performance that is at least two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical or (b) an overall score on a standardized measure of conceptual, social, and practical skills.[10]

[8] AAMD 8th ed. at 11.

[9] AAMR 9th ed. at 5.

[10] AAMR 10th ed. at 13, 14.

AAIDD 11th ed.	Performance that is approximately two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social or practical or (b) an overall score on a standardized measure of conceptual, social, and practical skills.[11]
DSM-III-R	Concurrent deficits or impairments in adaptive functioning, i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group in areas such as social skills and responsibility, communication, daily living skills, personal independence, and self-sufficiency.[12]
DSM-IV-TR	Significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/ interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.[13]

[11] AAIDD 11th ed. at 43.

[12] DSM-III-R at 32.

[13] DSM-IV-TR at 41.

DSM-5	At least one domain of adaptive functioning—conceptual, social, or practical—is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, at work, at home, or in the community.[14]

[14] DSM-5 at 38. The DSM-5 also requires that, "[t]o meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A." *Id.*