IN THE SUPREME COURT OF THE STATE OF NEVADA

Robert Ybarra, Jr.,

Appellant,

vs.

Terry Royal, Warden,

Appellee.

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CR-0001511, HC-2410004

DEATH PENALTY CASE

Appeal from the Seventh Judicial District Court

CORRECTED
Brief of Amicus Curiae American Association on Intellectual and Developmental Disabilities in Support of Appellant Robert Ybarra, Jr. and Reversal of the Seventh Judicial District Court

*Marc Picker
Marc Picker Law
Nevada State Bar No. 3566
Post Office Box 3344
Reno, NV 89505
Phone 775-391-1055

Ann M. Delpha, NM Bar No. 27834
James W. Ellis, DC Bar No. 213355
University of New Mexico
School of Law
1117 Stanford NE
Albuquerque, NM 87131

*Counsel of Record

Case No. 83531

Supreme Court of Nevada

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NRAP 26.1 DISCLOSURE

The undersigned counsel of record certifies that the following are persons and entities as described in Nev. R. App. P. 26.1(a), and must be disclosed. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

1. Marc Picker is appearing for amicus curiae the American Association on Intellectual and Developmental Disabilities.

2. The American Association on Intellectual and Developmental Disabilities is a non-profit corporation. It has no parent corporation, and no publicly held company owns 10% or more of its stock.

3. Pursuant to NRAP 29(c)(5), Amici Curiae provide the following:

   a. No party or party's counsel authored the brief in whole or in part;

   b. No person—other than the amicus curiae, its members, or its counsel—contributed money or other consideration intended to fund preparing or submitting the brief and, if so, identifies each person.

MARC PICKER LAW

/s/ Marc Picker
Marc Picker, Esq.
Attorney of Record for Amicus Curiae
The American Association on Intellectual and Developmental Disabilities

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IDENTITY OF *AMICUS CURIAE*[1]

THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ("AAIDD") founded in 1876, is the nation's oldest and largest organization of professionals in the field of intellectual disability. Primarily focused on clinical, psychological, scientific, educational, and habilitative issues, the Association also has a longstanding interest in legal issues that affect the lives of people with intellectual disability. AAIDD has formulated the clinical definition of intellectual disability. AAIDD, *Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports* 13 (12th ed. 2021). This definition has been embraced by the American Psychiatric Association and the World Health Organization. *Id.* at 15, 17, 20; *see* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 37–46 (5th ed., text rev. 2022) (Intellectual Developmental Disorder); World Health Organization, *International Statistical Classification of Diseases and Related Health Problems* (5th ed., 11th rev. 2025) (Disorders of Intellectual Development).

[1] This brief is filed with the written consent of all parties. A Motion for Leave to File Amicus Curiae Brief in Support of Appellant is being filed contiguously with this Amicus brief..

Both as the formulator of the clinical definition of intellectual disability, and as an interdisciplinary membership organization concerned with maintaining appropriate professional standards in the diagnosis of intellectual disability, AAIDD and its members have a strong interest in the manner in which *Atkins* claims are evaluated by courts.

ARGUMENT

I. Introduction

The existence of people with intellectual disability has been recognized in every society throughout their recorded histories. *See The Story of Intellectual Disability* (Michael L. Wehmeyer, ed., 2013) (a treatise on the existence and treatment of people with intellectual disability throughout recorded history).[2] Scholars and clinicians began a systematic and methodical study of intellectual disability around 150 years ago with the intention of better understanding the

[2] The term "intellectual disability" is the current term for the condition once known as mental retardation. Nev. Rev. Stat. Ann. § 0.036(2) (West) (2013) (mandating that in almost all cases, the term 'intellectual disability' must be considered to have the same meaning as the term 'mental retardation' "with respect to rights and responsibilities of persons with such a condition and eligibility or qualification of persons with such a condition for any program, benefit or otherwise"). At one time, the term 'mental retardation' was a clinical term of art, but it evolved into a pejorative and is no longer used in clinical or legal parlance. However, it is still found in some earlier case law, scholarship, and individual case records.

condition and of providing support to people who have it. Philip Ferguson, *The Development of Systems of Supports: Intellectual Disability in Middle Modern Times (1800 CE to 1899 CE)*, in *The Story of Intellectual Disability* 79, 79-116 (Michael L. Wehmeyer, ed., 2013).

All the research, studies, examinations, and documentation over the last century and-a-half is in agreement that intellectual disability is a condition literally defined by deficits. AAIDD, *Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports* 1 (12th ed. 2021) [hereinafter *AAIDD Diagnostic Manual 12th ed.*] ("Intellectual disability ... is characterized by significant limitations both in intellectual functioning and in adaptive behavior ... ."). A diagnosis of intellectual disability requires that the individual have significant difficulties with intellectual functioning (e.g. comprehension and thinking ahead) as well as with adaptive functioning (e.g. hygiene, cooking, using public transportation). Additionally, these problems must first become noticeable while the individual is still developing. *See id.* at 13; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 37 (5th ed., text rev. 2022) [hereinafter *DSM-5-TR*]. Because intelligence is generally stable over the lifespan, intellectual disability is a life-long condition and every person who has this condition will struggle with at least some tasks most people can perform with ease. *See DSM-5-TR* at 39-41, 43.

Longstanding study of intellectual disability has resulted a large body of knowledge regarding the condition, its features and the requirements for clinicians to conduct an accurate and correct diagnosis. *See, e.g.*, *AAIDD Diagnostic Manual 12th ed.*; *APA* [American Psychological Association] *Handbook of Intellectual and Developmental Disabilities* (Laraine Masters Glidden et al. eds., 2021); DSM-5-TR at 37-46; *see also* Alfred Binet & Th. Simon, *The Intelligence of the Feeble-Minded* (1916); A. F. Tredgold, *Mental Deficiency* (1908).

Although the diagnostic prongs may seem straightforward, an accurate clinical diagnosis of intellectual disability is a complex and exacting process. *See* Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 117 (2009). As a result, there is a significant risk of error in diagnosing intellectual disability if accepted clinical standards are not carefully followed. *See AAIDD Diagnostic Manual 12th ed.* at 38-44 (discussing best practices and requirements for a "precise and valid" diagnosis, and avoidance of false results).

The long-established clinical framework used in diagnosing intellectual disability bars any reliance on stereotypes, uninformed assumptions, or *ad hoc*, seat-of-the-pants assessments made by laypeople (or careless clinicians). A diagnosis informed by the clinical framework will instead apply careful assessment practices using clinical standards for evaluation and diagnosis. Using a non-clinical framework creates a very real risk of an unreasonable (and invalid) interpretation of the diagnostic facts in an *Atkins* evaluation. *See, e.g.*, *Brumfield v. Cain*, 576 U.S. 305, 312-320 (2015) (finding an unreasonable interpretation of the facts where a state court abandoned clinical standards in determining that an individual was ineligible for an *Atkins* adjudication). In the death penalty context, a clinically invalid assessment risks execution of an individual who has intellectual disability, a clear violation of the U.S. Constitution. *See Atkins v. Virginia*, 536 U.S. 304, 321 (2002) (execution of an individual with intellectual disability is prohibited by the Eighth Amendment of the U.S. Constitution).

This case presents several diagnostic issues that require the application of principles that are a part of the longstanding clinical diagnostic framework created by 150 years of research. Although long-settled in clinical practice, these issues may be challenging for courts (and even for clinicians who are unfamiliar with intellectual disability). Nonetheless, courts must resolve questions in intellectual disability evaluations using these longstanding clinical principles and cannot rely on concepts that have "no grounding in prevailing medical practice," or which replace a clinical assessment of intellectual disability with "lay perceptions" and "lay stereotypes" because the use of principles "not aligned with the medical community's information" "creat[es] an unacceptable risk that persons with intellectual disability will be executed." *Moore v. Texas*, (*Moore II*), 586 U.S. 133, 137 (2019) (quoting *Moore v. Texas*, (*Moore I*), 581 U.S. 1, 5, 18 (2017)).

Some familiarity with the definition of intellectual disability, the manifestation of the condition, and the clinical principles at issue may assist this Court in understanding and analyzing these diagnostic issues.

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

A. The Definition of Intellectual Disability.

A clinical diagnosis of intellectual disability begins with the three prongs that define the condition:

> Prong 1: "[S]ignificant subaverage general intellectual functioning which exists concurrently with";
> Prong 2: "deficits in adaptive behavior, and [which are]";
> Prong 3: "manifested during the developmental period."

Nev. Rev. Stat. 174.098(7) (West 2013) (formatting and prongs added for clarity).

B. Some Longstanding Clinical Canons Regarding the Manifestation of

Intellectual Disability.

The substantial body of knowledge regarding intellectual disability includes several long-established and core characteristics of the condition. Clinicians and scholars have categorized the different levels of impairment shown by people with intellectual disability, and have identified some common behavioral characteristics, as well as some principles regarding diagnosis when there are co-occurring conditions. These characteristics and principles will be discussed below.

1. **Classifications: Mild, Moderate, Severe, and Profound Intellectual Disability.**

Assessing the condition of intellectual disability includes developing an understanding of that individual's precise level of functioning. *AAIDD Diagnostic Manual 12th ed.* at 53. Clinicians may categorize functioning in terms of the magnitude of the person's impairment within the context of the intellectual disability using the terms "mild," "moderate," "severe" and "profound." *DSM-5-TR* at 39-41. Despite the apparently familiar words, they are clinical terms that can be misleading to courts and observers if they do not consider that these terms are used in relation to a condition that is defined by significant subaverage functioning.

The 'moderate,' 'severe' and 'profound' diagnostic categories of intellectual disability encompass people whose condition is usually immediately apparent even to lay observers, often due to atypical facial features or other physical differences. *See* Gilbert S. Macvaugh III & Mark D. Cunningham, Atkins v. Virginia: *Implications and Recommendations for Forensic Practice*, 37 J. Psychiatry & L. 131, 142 (2009) [hereinafter *Atkins Forensic Recommendations*]. Individuals in these diagnostic categories require more intensive support, and people with severe or profound intellectual disability typically need assistance with one or more basic life skills, such as communication, feeding, dressing, bathing, and toileting. DSM-5-TR at 40-41. As a group, individuals in these diagnostic categories represent between 10 and 20 percent of the people who have intellectual disability. *See* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 43-44 (4th ed., text rev. 2000). Generally, both because their level of support needs results in being chaperoned while in public and their condition is apparent to lay observers, individuals in these diagnostic categories are seldom (if ever) caught up in the criminal justice system or subject to criminal prosecution. *See Atkins Forensic Recommendations* at 142.

2. Most Individuals with Intellectual Disability Have 'Mild' Intellectual Disability.

People with intellectual disability whose adaptive behavior limitations fall into the 'mild' diagnostic category constitute the vast majority (approximately 80 to 90 percent) of the population of people with the condition. Martha E. Snell and Ruth Luckasson et al., *Characteristics and Needs of People with Intellectual Disability Who Have Higher IQs*, 47 Intellectual and Developmental Disabilities 220, 220 (2009). The term ‘mild’ is often misunderstood: this categorization is ‘mild’ *only* in comparison to the ‘moderate,’ ‘severe’ and ‘profound,’ diagnostic categories of intellectual disability; it is not ‘mild’ in comparison with the functioning of the general population. Because people with ‘mild’ intellectual disability usually lack obvious physical indicators of the condition, and, as discussed below, may have some basic verbal or other interpersonal strengths, they tend to blend into the general population at first glance. *See id.* Nonetheless, while they may be able to manage some tasks in a community setting without comprehensive support, individuals in this diagnostic category absolutely do have substantial deficits, functioning at a level lower than 97 percent of the general population. James W. Ellis, et al., *Evaluating Intellectual Disability: Clinical Assessments in* Atkins *Cases*, 46 Hofstra L. Rev. 1305, 1327-28 (2018) [hereinafter *Evaluating Intellectual Disability*].

Criminal defendants with intellectual disability are almost always among those with a ‘mild’ categorization, *Atkins Forensic Recommendations* at 142.

These individuals were addressed by the Court in *Atkins v. Virginia* when it discussed significant deficits of people with intellectual disability in the criminal justice system. *Atkins* held that people with intellectual disability frequently know right from wrong and may be competent to stand trial, but that "by definition they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others... . Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability." 536 U.S. 304 313, 318 (2002).

3. People with Intellectual Disability Often Attempt to Mask Their Deficits.

People with intellectual disability share the common human desire to be accepted and valued by others, but unfortunately, their condition often leads to significant abuse, stigma, and exclusion instead. AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 52 (11th ed. 2010). Physical and psychological abuse often begin in the schoolyard when other children realize that the child with intellectual disability is different, and easy prey. *See* Sasha M. Zeedyk et al., *Bullying Youth with IDD: Collateral Effects*, in *Maltreatment of People with Intellectual and Developmental Disabilities* 109, 109-35 (John R.

Lutzker, Kate Guastaferro & Megan L. Benka-Coker eds., 2016). Although more overt torment and physical assault tend to subside as children age, adults with intellectual disability bear a significant stigma in job hunting, making friends, and engaging in romantic relationships. Marisa H. Fisher, *Heightened Social Vulnerability Among Adults with IDD*, in *Maltreatment of People with Intellectual and Developmental Disabilities* 139, 139-56 (John R. Lutzker, Kate Guastaferro & Megan L. Benka-Coker eds., 2016).

To protect themselves from repeated abuse and exclusion, many people with intellectual disability develop a deeply ingrained, almost involuntary reflex to try to hide their deficits and appear more competent and functional than they actually are. *Evaluating Intellectual Disability* at 1366-68 & nn.252-255 (discussing studies documenting the tendency of people with intellectual disability to 'mask' the disability whenever possible); Robert B. Edgerton, *The Cloak of Competence* (rev. ed. 1993) (an extensive study of the phenomenon of masking). People with intellectual disability often mask, or hide, their disability even when it would be clear to the average person that masking is detrimental to them, such as when an economic or other benefit might be available if the disability were documented. *Evaluating Intellectual Disability* at 1366-68 & nn.252-255.

Among other common masking strategies, people with intellectual disability often rely on the unseen assistance of others to manage tasks which they themselves cannot perform. These hidden benefactors or supporters may help the person with intellectual disability with tasks such as reading or writing letters, performing basic financial transactions, understanding and following directions, etc. *See* Robert B. Edgerton, *The Cloak of Competence* 155 (rev. ed. 1993) (explaining that in order to maintain themselves in the community, people with intellectual disability find "benefactors" who help them with their problems).

4. The Risk of Stereotypes: People with Intellectual Disability Have Both Strengths and Weaknesses.

As previously discussed, every person with intellectual disability has substantial deficits, but people with the condition may have relative strengths as well. *AAIDD Diagnostic Manual 12th ed.* at 1 ("Within an individual, limitations often coexist with strengths."). While it is well-known and documented by clinicians, the idea that people with intellectual disability have both strengths and weaknesses can clash with societal expectations and impressions about the abilities of people with the condition. This may be at least in part because societal expectations and mental images of people with intellectual disability are often drawn from the more apparent and obvious disabilities of people whose limitations are in the 'moderate,' 'severe' and 'profound' diagnostic categories. *See Atkins Forensic Recommendations* at 142 ("[T]hose with mild [intellectual disability] who become involved in the criminal justice system typically do not exhibit stereotypical physical or behavioral characteristics commonly associated with severe [intellectual disability].").

Most people with intellectual disability can and do venture into the community on their own, at least to some extent. Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 121 (2009) ("Most individuals with [intellectual disability] will have strengths and areas of ability. These strengths may confound a layperson or a professional with limited clinical experience with individuals who have mild [intellectual disability]. These laypersons may erroneously interpret these pockets of strengths and skills as inconsistent with [intellectual disability] because of their misconceptions regarding what someone with [the condition] can or cannot do."). Reading, driving, graduating from high school, obtaining a GED, holding a job, playing games/sports, even marrying and having children are all within the abilities of some people with intellectual disability. *Evaluating Intellectual Disability* at 1403-04 & nn.379-82, 1405 n.383 (providing lists of studies discussing strengths and abilities commonly found in this population).

However, the presence of such strengths does not somehow 'balance' or 'negate' the deficits that are also present. In the diagnosis of intellectual disability, the individual's deficits are the only relevant concern. Clinical diagnostic principles mandate that strengths cannot be weighed against deficits, nor do they somehow 'cancel out' the deficits, and strengths may not be used 'rule out' a diagnosis of intellectual disability. Cecil R. Reynolds & Daneen A. Milam, *Challenging Intellectual Test Results*, in *Coping with Psychiatric and Psychological Testimony* 311, 330 (David Faust ed., 6th ed. 2012) (An individual with intellectual disability "cannot be disqualified from a diagnosis of [the condition] based upon scattered strengths or skills."). The only relevant diagnostic question is whether the individual has *deficits* at the level required by the definition. *See Moore v. Texas*, 581 U.S. 1, 15 (2017) ("[T]he medical community focuses the adaptive-functioning inquiry on adaptive deficits.").

5. People with Intellectual Disability Often Have a Co-Occurring Mental Illness.

Clinical research has shown that at least 40 percent of people with intellectual disability also have at least one co-occurring (also called 'comorbid') mental illness. *AAIDD Diagnostic Manual 12th ed.* at 104-05. Having such a comorbid mental illness (or any other disability) cannot be used to rule out a diagnosis of intellectual disability. *See Atkins Forensic Recommendations* at 152 ("[T]he presence of such a [mental illness] alone should not be assumed to account for observed deficient IQ scores, particularly when there is a history of intellectual limitations and adaptive behavior deficits.").

While mental illness should not preclude a diagnosis of intellectual disability, it can make an evaluation more challenging. 'Diagnostic overshadowing' is one such challenge in an evaluation where comorbidities are present. When a person has more than one mental disability, the most obvious problem or symptom is sometimes so blatant or clear that it obscures the presence of other, less visible problems. *See Evaluating Intellectual Disability* at 1366-68 & nn.252-255. In other words, when someone with intellectual disability also has a mental illness, any dramatic symptoms of that mental illness may obscure the less visible indicators of intellectual disability. American Association on Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* 174 (10th ed. 2002). For example, a clinician who observes that an individual is having an animated conversation with an invisible person may become so focused on the hallucinations and delusions that they do not recognize the individual's co-occurring intellectual disability. *See* Thomas E. Gift, John S. Strauss & Barry A. Ritzler, *The Failure to Detect Low IQ in Psychiatric Assessment*, 135 Am. J. Psychiatry 345 (1978).

III. Some Issues in Diagnosing Intellectual Disability.

A. An Introduction to the Diagnostic Process.

As discussed above, the definition of intellectual disability has three prongs, and all three prongs of the condition must be met for the condition to be diagnosed by a clinician. Through the decades of study regarding this condition, clinicians and scholars have built a clinical framework for the diagnosis of intellectual disability. This framework is based on longstanding, robust, and clear requirements, standards, and best practices that must be followed to obtain an accurate evaluation. Clinicians have also identified practices that are unacceptable and must not be used in an evaluation for intellectual disability.

To determine whether the individual meets the first prong, that is, whether the person has significant subaverage intellectual functioning, whenever possible clinicians must use an intelligence test. An intelligence test used to evaluate intellectual functioning for diagnostic purposes should be a standardized, full-length, well-evaluated and normed, individually-administered instrument given by a trained and experienced examiner. AAIDD, *Intellectual Disability: Diagnosis, Classification, and Systems of Supports* 35-42 (11th ed. 2010).

An evaluation of the second prong, significant deficits in adaptive behavior, should involve the administration, whenever possible, of a standardized adaptive behavior instrument. Tools such as the Vineland Adaptive Behavior Scales (Vineland) or the Adaptive Behavior Assessment Scales (ABAS), may be used with one or more relatives of the person being evaluated, or others who knew the person well as a child. *Id.* at 47-51. The purpose of this part of the evaluation is to determine whether and how well the individual could perform various conceptual, social, or practical tasks, and whether the individual could do them as well as an average person would do them. *Id.* These types of tasks might include things like basic arithmetic, counting change, being able to use a map correctly, reading and understanding a bus timetable, being able to wash oneself without prompting, or using a washing machine or a microwave safely.

The third prong, manifestation during the developmental period, is assessed by evaluating all the available records from the person's childhood, as well as the information gleaned from the adaptive behavior evaluation. This prong does not require a diagnosis during the developmental period, just evidence that the intellectual and adaptive behavior difficulties existed during this period. Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 Applied Neuropsychology 114, 115 (2009). For example, clinicians may consider failure to meet developmental milestones, consistent failure in school, being known as and called 'stupid' by relatives and/or peers, and other problems with functioning at an age-appropriate level in everyday life.

The evidence relevant to these prongs is often interrelated, and information relevant to one prong will often be relevant to the evaluation of the other two as well. The clinician gathers information to form an understanding of the individual's intellectual and adaptive functioning both during the developmental period, and afterward, as reflected in testing, records, and recollections of the person and others who knew the person when they were functioning in the world.

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

In reviewing records related to each of the three diagnostic prongs, evaluators in *Atkins* cases must consider reports of the examinee's functioning with caution, particularly reports from observers who lack clinical experience with intellectual disability. Stereotypes about people with intellectual disability may lead observers to make false assumptions about the abilities that a person with intellectual disability *could* have. In addition, an individual's own masking behaviors may lead to misperceptions about which abilities and deficits that individual actually *does* have. *Evaluating Intellectual Disability* at 1406-07 & nn.384-89 (discussing the problem of lay informants and stereotypes).

In other words, misconceptions about the existence of a definitive cap on the possible abilities in people with intellectual disability, the individual's masking of their own deficits, and diagnostic overshadowing, can all mislead lay observers (and even clinicians who do not have experience with intellectual disability). Such observers may report these mistaken facts or inaccurate conclusions in records that are eventually reviewed by a clinician as part of an evaluation. For example, an observer may incorrectly conclude that a person who could drive a car could not possibly have intellectual disability. The observer may then write that conclusion (but not the basis for it) in a report. Alternatively, an observer might incorrectly assume that a person with intellectual disability authored a sophisticated letter or even al legal brief, when the document was actually written by a benefactor and only signed (or even hand-copied) by the person with intellectual disability. The observer may report that the person with intellectual disability wrote the document.

An evaluating clinician who fails to investigate such observer reports thoroughly risks accepting some or all of this faulty information and then compounding the error by using that faulty information as a reason to ignore (or discredit) the severity of the individual's actual deficits, attributing them to a lack of effort rather than a lack of ability. *Id.* at 1407 (Evaluators "should focus on specific, concrete observations of . . . limitations" because "[o]therwise, there is a substantial risk that the assessment is built on a stereotype about intellectual disability of which the evaluator (and the court) may be unaware.").

C. Clinical Requirements and Standards Regarding Psychological Testing.

1. An Introduction to Psychometric Tests and Intelligence Testing.

Psychologists have refined and expanded their understanding of the human mind for well over a century and have devised hundreds (perhaps even thousands) of different psychometric instruments to test, assess, measure, and evaluate various aspects of human personality, mental pathology, and intellectual ability. *See, e.g.*, Gary Groth-Marnat & A. Jordan Wright, *Handbook of Psychological Assessment* (6th ed. 2016) (analyzing some of the most widely used tests of intelligence and personality). Many of the tests themselves, as well as the process of testing, have undergone extensive study and criticism by psychologists and psychometricians. *See, e.g.*, Anne Anastasi & Susana Urbina, *Psychological Testing* (7th ed. 1997) (a textbook devoted to the skills of psychological test administration as well as the features of some of the most commonly used tests).

A clinician must select tests deliberately, and with a full understanding of each test's quality and its intended use, as well as an understanding of the extent of the nexus between the information the test can provide and the question to be answered. *See* American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, *Standards for Educational and Psychological Testing* 142-43 (2014). Clinicians must also be sure to select tests that have been properly constructed and normed (that is, the instrument has been tested on an appropriate cross-section of the population before general use). *Id*. at 104. Tests must have a high level of validity (the extent to which the test actually measures what it is intended to measure), as well as a high level of reliability (the extent to which a different examiner would get the same results if administering the same test to the same subject). *Id.* at 11–47 (explaining the need of and purpose for high validity and reliability in psychological tests). An instrument chosen to measure the intelligence of someone who may have intellectual disability must have been normed and validated on a population that includes people with the condition. *Evaluating Intellectual*

Disability at 1351-52 & nn.186-88 (2018) (discussing studies and articles detailing the requirement of norming on relevant populations).

2. The Intelligence Test Selected Must Be Clinically Appropriate.

Whenever possible, the first prong of the definition, substantial deficits in intellectual functioning, should be determined using a test *designed* to measure intelligence; specifically a current, valid, and standardized test to measure intelligence. AAIDD, *Intellectual Disability: Diagnosis, Classification, and Systems of Supports* 35-42 (11th ed. 2010). There are several intelligence tests that meet the high technical standards of quality required in assessing intelligence for a diagnosis of intellectual disability.

Currently, the Wechsler Adult Intelligence Scale series and the Stanford-Binet Intelligence Scale series are the principal tests that satisfy these requirements. *See WAIS-IV Clinical Use and Interpretation* (Lawrence G. Weiss et al. eds., 2010); Gale H. Roid & R. Andrew Barram, *Essentials of Stanford-Binet Intelligence Scales (SB5) Assessment* (2004) (both texts provide in-depth discussions of these tests and their components). To arrive at a full-scale intelligence score, these tests employ multiple subtests which are designed to measure every aspect of an individual's intellectual functioning. *See, e.g.*, Lisa

Whipple Drozdick et al., *The Wechsler Adult Intelligence Scale – Fourth Edition and the Wechsler Memory Scale – Fourth Edition* in *Contemporary Intellectual Assessment* 197, 197-207 (Dawn P. Flanagan and Patti L. Harrison eds. 3d ed. 2012) (discussing the WAIS-IV contents, as well as its purpose and uses). The result of the subtest scores, when considered together, is the "full scale intelligence quotient" score, sometimes abbreviated as the "FSIQ." *Id.* at 200. This full-scale score is the IQ test result that is reported by the examiner and considered by evaluators and clinicians in making important intelligence functioning assessments; it is also the measurement in which the first prong of the diagnosis of intellectual disability is grounded. *AAIDD Diagnostic Manual 12th ed.* at 28 ("In reference to determining significant limitations in intellectual functioning, a full-scale IQ score should be used.").

Other intelligence tests can be faster and easier to administer but those tests are less robust and should not be used to diagnose intellectual disability because they generally only provide a rough guess as to an approximate intelligence level. These include 'short tests,' group tests (such as those given in prisons or in the military), and tests which are not designed to measure FSIQ, but which use a simplistic method for incidentally extrapolating a quick IQ estimate. These types of tests are generally not clinically acceptable choices for intellectual disability diagnosis and should not be used to rule out the condition. *Evaluating Intellectual Disability* at 1354-57 & nn.199-208 (discussing multiple studies documenting the inadequacy of short or group tests for the diagnosis of intellectual disability).

3. The Scoring and Administration of Intelligence Tests Must Be Free of Errors.

Even the most robust, valid, and well-normed testing instrument will produce an invalid result if the clinician makes errors in administering or scoring the test. The risk of these types of errors is heightened if the clinician is inexperienced, is in training, or is unfamiliar with people with intellectual disability. *See* Anne Anastasi & Susana Urbina, *Psychological Testing* 10-11 (7th ed. 1997) (explaining the need for a "qualified examiner" in test selection, administration, scoring, and score interpretation, noting that examiners must understand "the need to follow instructions precisely," have a "thorough familiarity with the standard instructions," and keep "careful control of the testing conditions," and advising that "incorrect or inaccurate scoring may render the test score worthless"). But even an experienced and qualified professional can make errors in administration and scoring that compromise or invalidate the test's results. *Id.* at 11 ("In the absence of proper checking procedures, scoring errors are far more likely to occur than is generally realized."); *see also Evaluating Intellectual Disability* at 1351 & n.184 (collecting studies documenting the types and frequency of examiner errors in testing).

Moreover, the administrator's own expectations about the subject's capabilities can affect (and distort) test results. *See* Paul A. McDermott, Marley W. Watkins & Anna M. Rhoad, *Whose IQ Is It? Assessor Bias Variance in High-Stakes Psychological Assessment*, 26 Psychological Assessment 207, 208 (2014) ("Administration and scoring biases, most especially pervasive types, undermine the purpose of testing. Their corrupting effects are exponentially more serious when testing purposes are high stakes, and there is abundant evidence that such biases will operate to distort major score interpretations, to change results of clinical trials, and to alter clinical diagnoses and special education classifications."); *see also* Robert L. Schalock and Ruth Luckasson, *Clinical Judgment* 38 (2d ed. 2014) (discussing the issue of clinicians relying on stereotypes). Because errors in testing can easily occur, and because there is no alarm mechanism to alert the examiner of an error, when a diagnosis of intellectual disability carries significant consequences, subsequent evaluators may consider prior testing scores with some caution. A careful evaluator will review the raw test data – the scores on individual items and subtests, the examinee's responses, and any notes or other documentation concerning the testing whenever possible. This information can be critical to validating the accuracy of any prior testing, particularly when the results of that prior testing diverge from the results of other administrations of the same or a similar test.

4. Successfully Malingering on Intelligence Tests Is Very Difficult.

While it may seem that a motivated individual could easily and successfully 'fake' intellectual disability in order to gain a benefit, such efforts are actually quite difficult. Similarly, malingering on an intelligence test is much more difficult than one might expect. Neither the specific test questions on IQ tests nor the manuals for those tests are available to the general public, and so the examinee is unlikely to know much about the test content or process. Anne Anastasi & Susana Urbina, *Psychological Testing* 10 (7th ed. 1997) ("There are two principal reasons for controlling the use of psychological tests: (a) to ensure that the test is given by a qualified examiner and that the scores are properly used; and (b) to prevent general familiarity with the test content, which would invalidate the test."). Additionally, all subtests of an instrument may not necessarily be given in every circumstance. *Id.* at 207-210 (outlining the subtests and administration of the

Stanford Binet and Wechsler tests). Further, the items in the subtests are generally progressive, meaning that each question is a little harder than the one before. *Id.* It would be very difficult for an untrained examinee to know or even guess precisely which subtests will be given, the order in which they will be given, or when to begin deliberately answering incorrectly. As a result, any intentionally poor effort is likely to be obvious and easily detectable to a trained examiner. Logically, it would be even more difficult to successfully malinger a similar score repeatedly on separate tests taken over a period of years. For each test, a malingerer would have to know the subtests and the questions, memorize the subtests and questions administered in that round of testing, and then, for each subsequent administration, remember which questions were answered correctly and which were not.

5. People with Intellectual Disability May Be Falsely Identified as Malingerers Using Some 'Effort Tests.'

Forensic clinicians sometimes use 'effort testing' (commonly thought of as a 'malingering test') to assess whether an examinee has put forth a good effort in answering the test questions during the evaluation. *See* Christopher L. Ray et al., *Assessment of Feigned Cognitive Impairment: A Cautious Approach to the Use of the Test of Memory Malingering for Individuals with Intellectual Disability*, 4 Open Access J. Forensic Psychology 24, 25-26 (2012) [hereinafter Ray, *A*

Cautious Approach]. As noted above, all psychological tests must be validated and normed on a wide cross-section of the population. If a test has not been normed on a particular subgroup of the population, using it on an individual from that subgroup risks producing invalid results. This is also true of effort tests used with people who may have intellectual disability. AAIDD recommends that such tests be used only with "considerable caution" because there has been little research supporting the accuracy of these tests when used on people with intellectual disability; the tests are too often misused even when the manual "explicitly precludes" use of the test on individuals with intellectual disability; and because most effort tests have not included people with the condition in their norming sample. AAIDD, *User's Guide to Accompany the 11th Edition of Intellectual Disability: Definition, Classification, and Systems of Supports* 24 (2012).

Effort tests which have not been normed on people with intellectual disability may be falsely interpreted as showing malingering, and so for this reason generally should not be used with an individual who may have intellectual disability. Ray, *A Cautious Approach* at 34 (discussing the high likelihood of false-positive error when a test not normed on people with intellectual disability is used to evaluate someone who may have that condition).

The Test of Memory Malingering (TOMM) is at issue in this case, and is one of the effort tests not normed on people with intellectual disability. *Id.* at 35. While some authorities suggest the test should not be used with the population of people with intellectual disability at all others have found that if the test is used with a person with intellectual disability, the administrator must use a lower cut-off for the score that indicates deception than the one designated in the manual for the general population. *Id.* at 35-40; s*ee also* Kolleen E. Hurley & William Paul Deal, *Assessment Instruments Measuring Malingering Used with Individuals Who Have Mental Retardation: Potential Problems and Issues*, 44 Mental Retardation 112, 116 (2006) (41 percent of people with intellectual disability were falsely identified as malingering using the cut-off scores in the TOMM manual).

In sum, if an unwary or uninformed clinician uses the TOMM but adheres to the cut-off score suggested in the manual, a test-taker who has intellectual disability may have given full effort on this test but obtain a score that falsely indicates malingering. The studies indicate that a conclusive decision that someone with intellectual disability is deliberately malingering on the TOMM should only be made if the individual's score is below the score that would be obtained by chance guessing. Ray, *A Cautious Approach* at 40. In other words, the individual must get so many answers wrong that statistically, they must be deliberately choosing the wrong answer, not just guessing incorrectly.

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

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

CONCLUSION

Clinicians and researchers have carefully built a well-established, robust and validated body of knowledge regarding the practices and standards necessary for an accurate evaluation of intellectual disability. Evaluators must adhere to the requirements of this clinical framework when making or ruling out a diagnosis of intellectual disability. An evaluator's (or court's) failure to adhere to this clinical diagnostic framework in an *Atkins* evaluation creates an unacceptably

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high risk of the execution of a person who has intellectual disability in violation of the Eighth Amendment of the U.S. Constitution.

Date: May 21, 2025

MARC PICKER LAW

/s/ Marc Picker
Marc Picker, Esq.

Ann M. Delpha
Staff Attorney/Adjunct Professor
University of New Mexico School of Law

James W. Ellis
Distinguished Professor Emeritus
University of New Mexico School of Law

CERTIFICATE OF COMPLIANCE

1. I hereby certify that this brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14 point Times New Roman.

2. I further certify that this brief complies with the page- or type-volume limitations of NRAP 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it is proportionately spaced, has a typeface of 14 points or more and contains 30 pages.

3. I also hereby certify that I have read this amicus curiae brief, and to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e)(1), which requires every assertion in the brief regarding matters in the record to be supported by a reference to the page and volume number, if any, of the transcript or appendix where the matter relied on is to be found. I understand that I may be

subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

Date: May 21, 2025

Respectfully Submitted,

MARC PICKER LAW

/s/ Marc Picker

Marc Picker, Esq.

CERTIFICATE OF SERVICE

I hereby certify that on 21st day of May, 2025, I electronically filed the foregoing document with the Nevada Supreme Court by using the appellate electronic filing system. The following participants in the case will be served by the electronic filing system:

Aaron Ford
Attorney General
Office of the Attorney General
100 North Carson Street
Carson City, Nevada 89701
jconner@ag.nv.gov

Melissa A. Brown,
White Pine County District Attorney
White Pine County Courthouse
1786 Great Basin Blvd., Suite 4
Ely, NV 89301
mabrown@whitepinecountynv.gov

Rene L. Valladares
Federal Public Defender
Randolph M. Fiedler
Assistant Federal Public Defender
Hannah D. Nelson
Assistant Federal Public Defender
411 E. Bonneville Ave., Ste. 250
Las Vegas, NV 89101
Randolph.fiedler@fd.org

/s/ Marc Picker

Marc Picker, Esq.
Marc Picker Law