No. 24-872

In the Supreme Court of the United States

JOHN Q. HAMM, COMMISSIONER,
ALABAMA DEPARTMENT OF CORRECTIONS,
Petitioner,

v.

JOSEPH CLIFTON SMITH,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR AMERICA FIRST LEGAL FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

DANIEL Z. EPSTEIN
America First Legal Foundation
611 Pennsylvania Ave. SE #231
Washington, DC 20003
(202) 964-3721
daniel.epstein@aflegal.org

CHRISTOPHER E. MILLS
Counsel of Record
Spero Law LLC
557 East Bay St. #22251
Charleston, SC 29413
(843) 606-0640
cmills@spero.law

Counsel for *Amicus Curiae*

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

OTHER AUTHORITIES

INTEREST OF *AMICUS CURIAE*

America First Legal Foundation is a nonprofit organization dedicated to promoting the rule of law in the United States by ensuring due process and equal protection for every American citizen and encouraging understanding of the law and individual rights guaranteed under the Constitution and laws of the United States. As President Trump recently explained, "politicians and judges who oppose capital punishment have defied and subverted the laws of our country," "seek[ing] to thwart the execution of lawfully imposed capital sentences and choos[ing] to enforce their personal beliefs rather than the law." Exec. Order No. 14164 § 1, 90 Fed. Reg. 8463 (Jan. 20, 2025), "These efforts to subvert and undermine capital punishment defy the laws of our nation, make a mockery of justice, and insult the victims of these horrible crimes." *Ibid.* Because AFL agrees that "laws that authorize capital punishment" should be "respected and faithfully implemented," *id.* § 2, it has a substantial interest in this case.*

---

* No counsel for a party authored this brief in whole or in part, and no person other than *amicus curiae*, its members, or its counsel monetarily contributed to it.

SUMMARY OF THE ARGUMENT

The decisions below are riddled with references to publications of several medical interest groups. See, *e.g.*, Pet. 34a–35a, 45a–48a, 51a–52a, 55a, 75a, 80a. Unlike in most areas of law, this Court's Eighth Amendment precedents consult these interest groups and allow their positions to affect the constitutional analysis. The Court should no longer defer to the shifting and advocacy-oriented positions of these interest groups, especially on questions like the one here, where these groups have no apparent view about how to consider multiple IQ tests.

The primary groups at issue are the American Psychiatric Association, the American Psychological Association, and the American Association on Intellectual and Developmental Disabilities (collectively, the "APAs"). These groups are resolutely opposed to the death penalty. They are entitled to that opposition, but their moral qualms about the death penalty should not supersede the continuing, broad support of Americans for this penalty as punishment for the most heinous crimes. At least when it comes to contentious issues like the death penalty, the APAs' positions stem in large part from their ideological viewpoints, not any objective science. There is no reason to think that this ideological rot does not infect their publications, including their diagnostic manuals.

Indeed, the APAs' claims of expertise about their diagnoses of intellectual disability are suspect. They decide relevant issues based on the select views of small committees, they disagree among themselves, and they continually change their definitions. The changes often appear to result from ideological

pressure or litigation strategy, not science. And these groups appear to have taken no out-of-court position with any detail about how to consider multiple IQ scores. One wonders whether that is because, other things equal, multiple IQ scores obviously increase accuracy, potentially leading to more death penalty-eligible murderers—and limiting the ability of purported "experts" to declare otherwise based on some "holistic" review. Whatever the reason, no possible medical "consensus" could rebut Alabama's approach to multiple IQ scores.

So especially on this issue—but also on Eighth Amendment questions more generally—the Court should not defer to whatever the APAs might say. How to balance considerations of deterrence, retribution, and culpability are for the People, and the APAs have no relevant expertise to engage in this complex balancing. The People, through their laws and juries, are entitled to execute brutal murderers like Respondent.

The Court should reverse.

ARGUMENT

I. The APAs are driven by ideology—not science.

This Court's Eighth Amendment precedents are permeated by an unusually rosy picture of medical consensus. In most areas of law, this Court has properly recognized that "[t]he views of self-proclaimed experts do not 'shed light on the meaning of the Constitution.'" *United States* v. *Skrmetti*, 145 S. Ct. 1816, 1840 (2025) (Thomas, J., concurring) (quoting *Dobbs* v. *Jackson Women's Health Org.*, 597 U.S. 215, 272–273 (2022)). Among other problems with

deferring to supposed expert consensus, that consensus is often wrong—especially "[i]n politically contentious debates over matters shrouded in scientific uncertainty." *Id.* at 1849; see *id.* at 1837 (majority opinion).

Errors may stem from ideology, self-interest, ignorance, groupthink, or any combination of these factors. And they are common in the medical field, just like any other field.[1] Thus, the danger of relying on purported medical consensus is that it may reflect little more than underlying ideological commitments, as medical interest groups release evidence-free statements and reference manuals that fit their desired narrative. Other *amici* have documented this phenomenon in recent cases before the Court, including about the American Psychological Association.[2]

Yet this Court's Eighth Amendment precedents have largely glossed over these problems. Instead, they have suggested that constitutional determinations should be "informed by the medical community's diagnostic framework." *Hall* v. *Florida*, 572 U.S. 701, 721 (2014); see, *e.g.*, *id.* at 710, 711, 723 (deferring repeatedly to "the medical community," "medical

---

[1] See M. Makary, *Blind Spots: When Medicine Gets It Wrong, and What It Means for Our Health* (2024).

[2] See, *e.g.*, Brief for Family Research Council as *Amicus Curiae* 4–28, *Chiles* v. *Salazar*, No. 24-539, 2025 WL 1698827 (U.S. June 12, 2025) ("FRC *Chiles* Brief"); Brief for Family Research Council as *Amicus Curiae* 6–28, *Skrmetti*, No. 23-477, 2024 WL 4594889 (U.S. Oct. 15, 2024); Brief of Alabama as *Amicus Curiae*, *Skrmetti*, No. 23-477, 2024 WL 4525181 (U.S. Oct. 15, 2024).

experts," and "established medical practice"). But there is no reason to trust these interest groups when it comes to questions about capital punishment.

A. The APAs' views about the death penalty are not oriented toward science.

For starters, these interest groups are vociferously opposed to the death penalty based on their own moral views. The American Psychological Association has called on "each jurisdiction in the United States that imposes capital punishment not to carry out the death penalty" until supposed "deficiencies" have been addressed and correction "shown through psychological and other social science research."[3] The APA cherry-picked studies supposedly showing a lack of "deterrent effect"—ignoring the inherent deficiencies in that research and research showing the opposite. See, *e.g.*, *Glossip* v. *Gross*, 576 U.S. 863, 897 (2015) (Scalia, J., concurring); *Gregg* v. *Georgia*, 428 U.S. 153, 185 (1976) (plurality opinion).

The APA also ignored other reasons for the death penalty, including that it expresses "the community's belief that certain crimes are themselves so grievous an affront to humanity that the only adequate response may be the penalty of death." *Id.* at 184. "This function" "is essential in an ordered society that asks its citizens to rely on legal processes rather than self-help to vindicate their wrongs." *Id.* at 183; see also *Glossip*, 576 U.S. at 932 (Breyer, J., dissenting) ("Retribution is a valid penological goal.").

---

[3] American Psychological Association, *The Death Penalty in the United States* (Aug. 2001), https://perma.cc/564S-KZEU.

A past APA president, Dr. Donald N. Bersoff**,** urged "the abolition of the death penalty" as "the moral and ethical thing to do."[4] He claimed (without citation) that "retribution is founded in the unscientific belief that behavior is the result of free will."[5] He said that "any decently trained psychologist knows that behavior is not so unfettered" and that "there are no heroes and no villains."[6]

More recently, the APA voted 161 to 7 to pass a resolution citing "inclusion" and "diversity" in proclaiming it "morally abhorrent" to apply the death penalty when the criminal was 18–20 years old.[7] The APA invoked its prior *amicus* brief in *Roper* v. *Simmons*, which said that adolescents have "[d]evelopmentally immature decision-making, paralleled by immature neurological development."[8] The APA's said this same "immaturity" applies until age 21, "especially in the key brain systems implicated in a person's capacity to evaluate behavioral options, make rational decisions about behavior, meaningfully consider the consequences of acting and not acting in

---

[4] American Psychological Association, *APA Should Stand Up Against the Death Penalty*, Monitor on Psychology (Oct. 2013), https://perma.cc/W4ST-WN6K.

[5] *Ibid.*

[6] *Ibid.*

[7] American Psychological Association, *APA Resolution on the Imposition of Death as a Penalty for Persons Aged 18 Through 20, Also Known As the Late Adolescent Class* (Aug. 2022), https://perma.cc/G6ET-LYC6.

[8] Brief for American Psychological Association et al. as *Amici Curiae* 2, *Roper* v. *Simmons*, No. 03-633, 2004 WL 1636447 (U.S. July 19, 2004).

a particular way," and much else.[9] The APA also fretted about the effect of the death penalty on "those with nontraditional sexual orientations," without pointing to specific examples.[10]

Likewise, the American Psychiatric Association in 2020 passed a "Position Statement on Issues Pertaining on Capital Sentencing and the Death Penalty" endorsing a "moratorium on capital punishment in the United States."[11]

If it were not already clear that the two APAs' stances and arguments about the death penalty are driven by their view that execution is "morally abhorrent in a developed society that is concerned with equality,"[12] consider what they told this Court in *United States* v. *Skrmetti*. There, the two APAs waved away all concern about the ability of juveniles to consent to permanently sterilizing sex hormones and surgeries for transitioning purposes, reasoning that adolescents can "ha[ve] the emotional and cognitive maturity required to provide informed consent/ assent."[13] Yet they tell us that even criminals who

---

[9] *APA Resolution*, *supra* note 7, at 1–2.
[10] *Id.* at 3.
[11] American Psychiatric Association, *Position Statement on Issues Pertaining to Capital Sentencing and the Death Penalty* (July 2020), https://perma.cc/LK4Z-8PCQ.
[12] *APA Resolution*, *supra* note 7, at 4.
[13] Brief of American Psychological Association et al. as *Amici Curiae* 15, *Skrmetti*, No. 23-477, 2024 WL 4101400 (U.S. Sept. 3, 2024); see Brief of American Psychiatric Association et al. as *Amici Curiae* 12, *Skrmetti*, No. 23-477, 2024 WL 4135277 (U.S.

were 20 when they committed murder cannot be subject to capital punishment because they "possess a lack of maturity" and cannot adequately "resist outside pressures."[14] The difference? The APAs morally support transitioning children and morally oppose executing murderers.

As for AAIDD, it insists that "individuals with intellectual disability" "must" "be exempt from the death penalty because existing case-by-case determinations of competence to stand trial, criminal responsibility, and mitigating factors at sentencing have proved insufficient to protect the rights of individuals with intellectual disability."[15] It complains of "unfair and inaccurate procedures" from States and calls for them to be required to conform their procedures to "the national standards"—by which AAIDD means its own preferences.[16]

Together, the APAs have filed many *amicus* briefs before this Court addressing capital punishment.[17] In

---

Sept. 3, 2024); see generally C. Jones, *The Façade of Medical Consensus: How Medical Associations Prioritize Politics Over Science*, 2025 Harv. J. L. & Pub. Pol'y Per Curiam 1, 6–8.

[14] *APA Resolution*, *supra* note 7, at 1–2.

[15] AAIDD, *Criminal Justice System: Joint Position Statement of AAIDD and The Arc* (2014), https://perma.cc/66K2-WNUH.

[16] *Ibid.*

[17] See, *e.g.*, Brief of American Psychological Association, et al. as *Amici Curiae* in Support of Petitioner, *McCarver* v. *North Carolina*, No. 00-8727, 2001 WL 648606 (U.S. June 8, 2001); Brief of American Psychological Association, et al. as *Amici Curiae* in Support of Petitioner, *Hall*, No. 12-10882, 2013 WL 6805688

no instance do they appear to have supported capital punishment.

"Capital punishment presents moral questions that philosophers, theologians, and statesmen have grappled with for millennia." *Glossip*, 576 U.S. at 899 (Scalia, J., concurring). While the APAs are entitled to their moral opposition to the death penalty, no one should pretend that their statements about the death penalty stem from anything else—certainly not some neutral scientific posture.

B. The APAs' other positions confirm their ideological orientation.

The APAs' ideological orientation is confirmed by their policies and actions outside the capital punishment context. Starting with the American Psychological Association, another recent *amicus* brief

---

(U.S. Dec. 23, 2013) ("*Hall* APA Brief"); Brief for American Psychological Association, et al. as *Amici Curiae* in Support of Petitioner, *Madison* v. *Alabama*, No. 17-7505, 2018 WL 2427451 (U.S. May 29, 2018); Brief of American Psychological Association, et al. as *Amici Curiae* in Support of Petitioner, *Moore* v. *Texas*, No. 15-797, 2016 WL 4151451 (U.S. Aug. 4, 2016) ("*Moore* APA Brief"); Brief of American Psychological Association, et al. as *Amici Curiae* in Support of Petitioner, *Moore* v. *Texas*, No. 18-443, 2018 WL 5876923 (U.S. Nov. 8, 2018); Brief for American Psychological Association, et al. as *Amici Curiae* in Support of Petitioner, *Panetti* v. *Quarterman*, No. 06-6407, 2007 WL 579235 (U.S. Feb. 21, 2007); Brief of American Association on Intellectual and Developmental Disabilities, et al. as *Amici Curiae* in Support of Petitioner, *Hall*, No. 12-10882, 2013 WL 6827753 (U.S. Dec. 23, 2013); Brief of American Association on Intellectual and Developmental Disabilities, et al. as *Amici Curiae* in Support of Petitioner, *Moore*, No. 15-797, 2016 WL 4151447 (U.S. Aug. 4, 2016).

explained that the APA has a "heinous record" on many issues and "continues to make pronouncements dictated by ideology, not sound science."[18] The APA "regularly relies on far-left concepts that lack empirical examination," and its ideology also influences "the reporting and execution of psychological research in a top-down manner."[19] It has "largely moved beyond trying to report objective scientific facts, taking on a primary role of advocating for certain public policies" and "reveal[ing] an especially lopsided shift toward advocacy."[20] The APA's "advocacy goals and resulting statements are typically a product of self-selected political inclinations rather than a representation of the perspectives of the psychological community."[21] The APA's "ideological bent infects its legal work too," as the APA "churns out *amicus* briefs that are outside its supposed expertise or misrepresent science."[22] The group's "eagerness to insert its ideological preferences is far-reaching."[23]

The APA continues to garner controversy. Recently, "[m]ore than 3,500 mental health professionals have sent a letter to the [APA's leaders]" "rebuking them for allowing 'virulent antisemitism' to

---

[18] FRC *Chiles* Brief 8, 10.
[19] *Id.* at 11.
[20] *Id.* at 13.
[21] *Ibid.*
[22] *Ibid.*
[23] *Ibid.*

fester in their ranks."[24] The letter revealed that "Jewish APA members have been harassed, marginalized, and silenced on APA community forums [] for attempting to challenge antisemitic rhetoric or correct misinformation."[25] The Anti-Defamation League and the Academic Engagement Network said that they "are deeply alarmed by reports of the rising tide of antisemitism within the American Psychological Association," and warned that the medical group's "credibility depends on its willingness to confront this moment with integrity."[26] These allegations are unsurprising, given the APA's tendency to censor and silence dissenting voices.[27]

Things are little better at the American Psychiatric Association, which like the American Psychological Association has gone on several apology tours seeking forgiveness for its past mistakes, including an apology to "Black, Indigenous, and People of Color for its support of structural racism in psychiatry."[28] Its apology details how "late 20th century psychiatrists commonly attributed their minority patients'

---

[24] S. Satel, *American Psychological Association Slammed for 'Virulent' Jew Hate*, The Free Press (Feb. 25, 2025), https://tinyurl.com/yeyrpct7.

[25] *Ibid.*

[26] Anti-Defamation League, *ADL and AEN Urge the American Psychological Association to Address Antisemitism* (May 30, 2025), https://perma.cc/2YMF-AGB2.

[27] See, *e.g.*, FRC *Chiles* Brief 12–13, 30.

[28] American Psychiatric Association, *APA Apologizes for Its Support of Racism in Psychiatry* (Jan. 18, 2021), https://perma.cc/9K5M-H38F.

frustrations to schizophrenia, while categorizing similar behaviors as 'neuroticism' in white patients."[29]

Much like the American Psychological Association, the American Psychiatric Association is no stranger to kowtowing to the whims of ideological activist groups when deciding what the "medical consensus" is. Take the APA's *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"), repeatedly relied on as near-gospel by this Court's precedents. See, *e.g.*, *Moore* v. *Texas*, 581 U.S. 1, 20 (2017) ("Reflecting improved understanding over time, current manuals offer the best available description of how mental disorders are expressed and can be recognized by trained clinicians." (cleaned up) (citing DSM)).

"LGBTQ+ activists achieved what was called the 'greatest gay victory' of the time: successfully pushing members of the American Psychiatric Association [] to remove the diagnosis of homosexuality from the official classification of mental illnesses" in the DSM.[30] Activists went "straight to the source" by attending conferences hosted by the APA to press the group to revise its scientific manual.[31] At least one activist at a conference yelled at the APA's members to get "off of the couches and into the streets!"[32] The

---

[29] *Historical Addendum to APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry* (Jan. 18, 2021), https://perma.cc/CL7Q-YE2Z.
[30] R. Uyeda, *How LGBTQ+ Activists Got "Homosexuality" Out of the DSM*, JSTOR Daily (May 26, 2021), https://perma.cc/7VVZ-KD36.
[31] *Ibid.*
[32] *Ibid.*

activists demanded that the APA get in line, and the medical group obliged.

Also like the American Psychological Association,[33] the American Psychiatric Association eagerly comments on issues that are loosely tied—if at all—to psychiatry. In recent months, the APA accused this Court of "strip[ping] patients and families of the choice to direct their own health care" following *Skrmetti*,[34] advocated for climate change efforts after an APA-commissioned poll found that over 40% of adults had personally experienced effects on their mental health due to climate change,[35] and opposed an executive order about gender dysphoria and military service.[36]

Last, AAIDD too is not shy that its first "major objective" is to "[a]dvance progressive policies . . . that result in social justice."[37] It seeks "to influence policy," including by "[p]rovid[ing] information . . . to jurists and others in the criminal justice system."[38] And like the two APAs, it does not limit its policy statements to areas within its expertise. One recent statement declared "that racism is at the forefront of th[e]

---

[33] See FRC *Chiles* Brief 13–16.
[34] American Psychiatric Association, *A Statement on the Supreme Court Decision* (June 18, 2025), https://perma.cc/NL2J-JFXC.
[35] American Psychiatric Association, *One-Third of Americans Worry About Climate Change Weekly* (June 18, 2025), https://perma.cc/N58L-EB8J.
[36] American Psychiatric Association, *APA Statement on Gender Dysphoria and Military Readiness* (Feb. 28, 2025), https://perma.cc/6W4W-K7K8.
[37] AAIDD, *AAIDD Strategic Plan 2024–2025* (July 29, 2024), https://perma.cc/4CFX-P475.
[38] *Ibid.*

oppression" "that form[s] inequities for Black people in our country," with AAIDD pledging to support "antiracism."[39] Its conferences—which purport to be scientific gatherings—have opened with a chorus singing "We are an LGBT people, and we are pleading, pleading for our lives."[40]

All this provides ample reason for the Court to treat the APAs' pronouncements—and any arguments they make here—as it would the arguments of any other interest group with ideological commitments. The votes of a few dozen purported experts—most of them categorically opposed to the death penalty—should not set a constitutional standard that limits how the People's representatives punish crime.

II. The APAs' approaches to diagnoses are scientifically dubious.

Though this Court has relied on the APAs' diagnostic manuals in Eighth Amendment cases, those manuals have a suspect scientific basis. They are contradictory, subject to change without scientific justification, and produced by small groups of individuals with minimal empirical review.

---

[39] AAIDD, *Anti-Racism: Position of AAIDD* (Dec. 9, 2020), https://perma.cc/H29A-TX3G.

[40] AAIDD, X (Jun. 26, 2018), https://x.com/_aaidd/status/1011644183021580289.

A. The DSM is infected by ideology, not unanimous, and not science as generally understood.

As noted, this Court's Eighth Amendment precedents have placed heavy reliance on the American Psychiatric Association's DSM. The APA "began the current classification system, the *Diagnostic and Statistical Manual (DSM)* in 1952 in order to create a single 'classification that would be acceptable to all members.'"[41] "Descriptions and classifications were drawn from the consensus of clinicians, and this method has remained through to the present version—DSM-5."[42]

"Chief among the application problems with this *DSM* system is that of inter-rater reliability because the descriptions do not lend themselves to a single interpretation."[43] "[B]ecause similar symptoms of distress manifest[] in many diagnostic categories," researchers have noted the danger that clinicians "may be selectively perceiving and emphasizing only those characteristics and attributes of their patients which are relevant to their own preconceived system of thought."[44]

Thus, "the essential difficulties" with the DSMs "are diagnostic validity and reliability."[45] The "*validity* difficulty is that" the DSM lacks "a unifying

---

[41] 1 D. Lorandos et al., *Litigators Handbook of Forensic Medicine, Psychiatry and Psychology* § 3:15 (2024).
[42] *Ibid.*
[43] *Ibid.*
[44] *Ibid.*
[45] *Ibid.*

theory to guide diagnostic decision-making."[46] As for *reliability*, "[t]here is no available evidence that the procedures of the various DSMs have reduced the subjective biases associated with the diagnostic work of mental health professionals."[47] Rather, diagnoses "often reflect the ethnic- and social class prejudices of diagnosticians and the social stereotypes they associate with a particular disorder."[48]

The prior DSM, DSM-4, "clearly acknowledged its limitations" for evidentiary purposes.[49] So "one would suppose that when crafting the successor to the DSM-IV," addressing "the shortcomings in the classification system would have been at the top of the list" for the APA.[50]

One "would be wrong."[51] "[T]he DSM 5 had abysmal results in its field trials" for reliability, results that "were clearly predictable from the start."[52] When the APA's Board of Trustees approved the DSM-5, Professor Allen Frances of Duke University, Chairman of the DSM-4 Task Force, viewed it as the "saddest moment in [his] 45-year career studying, practicing, and teaching psychiatry."[53] Calling the DSM-5 "deeply flawed" and "containing many changes

---

[46] *Ibid.*
[47] *Ibid.*
[48] *Ibid.*
[49] *Ibid.*
[50] *Ibid.*
[51] *Ibid.*
[52] *Ibid.*
[53] A. Frances, *DSM-5 Is a Guide, Not a Bible—Simply Ignore Its 10 Worst Changes*, Psychiatric Times (Dec. 5, 2012), https://perma.cc/QC2F-3NDW.

that seem clearly unsafe and scientifically unsound," Professor Frances advised clinicians, the press, and the public to "be skeptical and don't follow [the] DSM-5 blindly down a road likely to lead to massive over-diagnosis and harmful over-medication."[54]

Even at its inception, the DSM-5 "got off to a bad start and was never able to establish sure footing."[55] "Its leaders initially articulated a premature and unrealizable goal [] to produce a paradigm shift in psychiatry,"[56] away from categorical diagnoses and toward "dimensional measures."[57] But little attention was "paid to the methodological rigour and comprehensiveness of the DSM-5 empirical review,"[58] and "[e]xcessive ambition combined with disorganized execution led inevitably to many ill-conceived and risky proposals."[59]

Though these ambitions were "vigorously opposed," the DSM-5 "has neither been able to self-correct nor willing to heed the advice of outsiders," and "has instead created a mostly closed shop–circling the wagons and deaf to the repeated and widespread warnings that it would lead to massive

---

[54] *Ibid.*
[55] *Ibid.*
[55] *Ibid.*
[56] *Ibid.*
[57] *Ibid.*
[57] M. First, *Paradigm Shifts and the Development of the Diagnostic and Statistical Manual of Mental Disorders: Past Experiences and Future Aspirations*, 55(11) Canadian J. Psychiatry, 692, 693 (2010).
[58] *Id.* at 697.
[59] Frances, *supra* note 53.

misdiagnosis."[60] In fact, as another academic pointed out, the DSM-5's "revision process suffered from lack of an adequate public record of the rationale for changes."[61] Discussions among the manual's Scientific Review Committee, a group "formed in response to the DSM-5 controversies to evaluate the strength of the scientific evidence for each proposed change and provide recommendations to the workgroups, [were] kept strictly secret."[62] This "needlessly secretive DSM-5 mindset" was "antithetical to both the appearance and reality of intellectual integrity."[63]

But perhaps the DSM-5's "greatest problem, and the target of the most vigorous and sustained criticism, was its failure to take seriously the false positives problem."[64] "By expanding diagnosis beyond plausible boundaries in ways inconsistent with DSM-5's own definition of disorder, DSM-5 threatened the validity of psychiatric research . . . ."[65] "Except for autism, all the DSM-5 changes loosen[ed] diagnosis and threaten[ed] to turn [the] current diagnostic inflation into diagnostic hyperinflation."[66] The concern was (and is) that "millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood,

---

[60] *Ibid.*
[61] J.C. Wakefield, *DSM-5, Psychiatric Epidemiology and the False Positives Problem*, 24(3) Epid. Pysch. Sci. 188, 188 (2015), https://perma.cc/AE24-E28E.
[62] *Id.* at 189
[63] *Ibid.*
[64] *Id.* at 188.
[65] *Ibid.*
[66] Frances, *supra* note 53.

the forgetting of old age, and 'behavioral addictions' will soon be mislabeled as psychiatrically sick and given inappropriate treatment."[67]

Other medical groups echoed this concern. The National Institute of Mental Health, "the world's largest funding agency for research into mental health," withdrew its support for the DSM-5 before it was even released.[68] It was concerned the manual's "diagnoses [were] based on a consensus about clusters of clinical symptoms, not any objective laboratory measure," leading to its "weakness": "its lack of validity."[69] Likewise, the British Psychology Society criticized the DSM-5's diagnoses as "clearly based largely on social norms," emphasizing that "[m]any researchers have pointed out that [its] psychiatric diagnoses are plagued by problems of reliability, validity, prognostic value, and co-morbidity."[70]

B. The APAs have disagreed about how to diagnose intellectual disability.

The DSM-5 affected the intellectual disability diagnosis too. The DSM-4 required as the "essential feature" of intellectual disability a "subaverage

---

[67] *Ibid.*; see generally Brief *Amicus Curiae* of the Criminal Justice Legal Foundation in Support of Respondent, *Moore*, No. 15-797, 2016 WL 5116850 (U.S. Sept. 13, 2016) ("*Moore* CJLF Brief") (making similar points).

[68] C. Lane, *The NIMH Withdraws Support for DSM-5*, Psychology Today (May 4, 2013), https://perma.cc/V5V6-43FQ.

[69] *Ibid.*

[70] British Psychological Society, *Response to the American Psychiatric Association: DSM-5 Development* (June 2011), https://perma.cc/KTZ4-EEER.

general intellectual functioning" "that is accompanied by significant limitations" in the individual's "adaptive functioning."[71] The DSM-5 took a different approach, naming *two* "essential features"—intellectual deficits and impairments in adaptive functioning—and requiring that "the deficits in adaptive functioning must be directly related to the [individual's] intellectual impairments."[72] The manual vaguely defined "adaptive functioning" as "how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background."[73] In other words, while the DSM-4 required only that an individual's subaverage intellectual functioning is *accompanied* by significant limitations to their adaptive functioning, the DSM-5 required that one was a cause of the other.

The seemingly subtle change created an obvious problem. This Court relied on the DSM-5 and the "medical community" in defining intellectual disability through three criteria: (1) "significantly subaverage intellectual functioning"; (2) "deficits in adaptive functioning"; and (3) onset of these deficits during the developmental period." *Hall*, 572 U.S. at 710 (citing DSM-5, at 33). The Court later said that scientific consensus and "[t]he medical community's current standards" supply a necessary "constraint on

---

[71] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 39 (4th ed. 1999).
[72] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 37–38 (5th ed. 2013).
[73] *Id.* at 37.

States' leeway" in defining intellectual disability under the Eighth Amendment. *Moore*, 581 U.S. at 20.

But there wasn't a consensus. Besides the DSM-5, this Court relied on the AAIDD 11th edition clinical manual.[74] See *Moore*, 581 U.S. at 13, 20. But the AAIDD-11 did not require "that adaptive deficits be 'related' to intellectual functioning," while the DSM-5 "*did* include that requirement." *Id.* at 24 (Roberts, C.J., dissenting).

This lack of consensus among the manuals and psychiatrists only intensified. On September 7, 2018—after *Hall* and *Moore*—the AAIDD urged that the DSM-5's approach to adaptive functioning be "deleted" from its diagnostic criteria.[75] The AAIDD said that the DSM-5's requirement was "neither possible for clinicians to ascertain nor empirically supported."[76] What's more, the AAIDD observed that "problems created by [the DSM-5's] phrase were not merely a theoretical concern, but that the practical impact of this change to the diagnostic criteria could easily be foreseen in . . . various legal issues in the criminal and civil justice systems."[77]

The American Psychiatric Association offered "a proposed revision" to the DSM-5 saying that "deficits in adaptive functioning are a consequence of

---

[74] AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2009) ("AAIDD-11").
[75] AAIDD, *AAIDD Opposes a Proposed Revision to the DSM-5's Entry for Intellectual Disability* (July 29, 2019), https://perma.cc/2MRR-AQFL.
[76] *Ibid.*
[77] *Ibid.*

intellectual deficits."[78] The AAIDD still "strongly oppose[d]" the suggested revision as "not supported by empirical evidence," arguing that the revision "mistakenly asserts causation that puts a primacy in diagnosis on IQ and creates internal inconsistency in the criteria by anchoring both clinical elements on the diagnosis in IQ."[79] The AAIDD argued that "there is no empirical evidence supporting the notion of a causal link between intellectual functioning and adaptive behavior."[80] And the AAIDD said that the DSM-5's understanding "[r]epresent[ed] a significant and dramatic departure from previous DSM manuals, contradict[ed] current clinical and scientific consensus, and [was] out of step with other diagnostic systems (i.e., the World Health Organization's ICD and AAIDD)."[81]

Nor was the back-and-forth between the medical groups confined to the role of adaptive functioning. For instance, the AAIDD-11 required intellectual disability to "originate[] before age 18." AAIDD-11, at 1. Meanwhile, the DSM-5 required onset of intellectual and adaptive deficits during the (vaguely defined) "developmental period." DSM-5 at 33. And the latest AAIDD manual, the 12th edition, moves onset to the "developmental period" too, which "is

---

[78] C. Perkes, *Psychiatrists Considering Change to Intellectual Disability Criteria*, Disability Scoop (Aug. 12, 2019), https://perma.cc/456U-T69T.
[79] *AAIDD Opposes*, *supra* note 75.
[80] *Ibid.*
[81] *Ibid.*

defined operationally as before the individual attains age 22."[82]

AAIDD's own manual has caused disagreements too. As Justices of this Court pointed out, the majority opinion in *Moore* relied on "the AAIDD's direction that 'significant limitations in conceptual, social, or practical adaptive skills [are] not outweighed by the potential strengths in some adaptive skills.'" *Moore*, 581 U.S. at 31 (Roberts, C.J., dissenting) (citing AAIDD-11, at 47). "Even assuming that all clinicians would agree with this statement, there are a number of ways it might be interpreted . . . ." *Ibid.* For instance, this statement may mean "that strengths in one of the three adaptive skill areas—conceptual, social, and practical—should not cancel out deficits in another; as meaning that strengths should not outweigh deficits within the same skill area; or as meaning that evidence of some ability to perform a skill should not offset evidence of the inability to perform that same skill." *Ibid*. And "clinicians do, in fact, disagree about what this direction means." *Ibid*. (collecting citations).

After *Moore*, the American Psychiatric Association revised the DSM-5, issued as the DSM-5-TR.[83] The DSM-5-TR was not immune from criticism, including being called "destructive" and "compound[ing] the

---

[82] AAIDD, *Intellectual Disability* 14 (12th ed. 2021) ("AAIDD-12").

[83] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (2022) ("DSM-5-TR").

DSM-5's colossal error[s]."[84] Like its predecessor, the manual revised (and generally relaxed) diagnostic criteria with little explanation.

Of special interest, the new revision deleted the DSM-5's controversial requirement that adaptative functioning must be directly related to the individual's intellectual impairments. Compare DSM-5 at 38, with DSM-5-TR at 42. The APA's stated reason for the revision was that the old phrase appeared to "inadvertently" "change the diagnostic criteria for Intellectual Disability to add a fourth criterion."[85]

But the "directly related" requirement wasn't inadvertent. Even when the APA was pressed by the AAIDD and other groups to revise the DSM-5's criteria for adaptive functioning, the APA would only say that "deficits in adaptive functioning are a consequence of intellectual deficits."[86] Time and again, the APA was urged to reevaluate its criteria, but the group would not budge. Even before this Court, the medical group emphasized that "[t]he current diagnostic criteria require a connection between the deficits in intellectual functioning and adaptive functioning."[87]

The APA's dubious explanation for its change does not show a new consensus of the roles and relationship between adaptative behavior and intellectual

---

[84] A. Frances, *Is DSM-5-TR Worth Buying?*, Psychiatric Times (Mar. 23, 2022), https://perma.cc/SBS3-NBZ8.
[85] American Psychiatric Association, *Intellectual Development Disorder (Intellectual Disability)*, https://perma.cc/JL9M-XHZ5.
[86] Perkes, *supra* note 78.
[87] *Moore* APA Brief 9.

impairment. Rather than show that the revision was made in response to a newfound scientific consensus, the APA simply labelled the prior definition as "inadvertent." Recent "[s]tudies examining the correlation between the adaptive behavior and intelligence of individuals with intellectual disabilities" continue to report "varying results."[88]

Similarly, AAIDD-12—while claiming that *it* alone provides "[t]he authoritative definition"—tries to paper over all the past and present disagreements in the field, implausibly claiming that all prior AAIDD and DSM manuals have been "consisten[t]" because "the APA has generally adopted, with some minor adaptations, the AAIDD definition and diagnostic criteria." AAIDD-12, at 14, 17. As shown, however, there was—and remains—no consensus in the "medical community" about these issues.

C. There is no plausible consensus against Alabama's approach to multiple IQ scores.

This disagreement among the medical community matters to the question before the Court of whether and how courts may consider the cumulative effect of multiple IQ scores in assessing an *Atkins* claim. First, there would little better indication that these groups are driven by ideology rather than science if they were to file an *amicus* brief in this case that glosses over the indisputable (and obvious) fact that, other things

---

[88] M. Tasse & M. Kim, *Examining the Relationship between Adaptive Behavior and Intelligence*, Behavior Sciences 2 (Mar. 13, 2023), https://perma.cc/YS2W-DTN7.

equal, multiple IQ tests "provide a more accurate estimate than each test alone." Pet. 2.

Second, that apparently nothing in these groups' manuals explores the question of multiple IQ scores in any detail shows that the purported scientific expertise of these groups has little to offer the Court here. Whatever is said in any brief they file will not even have the imprimatur of the (small) committees that author the manuals or the (small) audiences that vote on their policies. See *Ex parte Mays*, 686 S.W.3d 745, 751 n.3 (Tex. Crim. App. 2024) (Yeary, J., dissenting) (noting that these "manuals may not even accurately reflect the consensus of the psychiatric profession *itself*"). It will be generated for litigation purposes and align with the groups' ideological opposition to the death penalty.

Third, any claim of consensus will be illusory. The two APAs previously told this Court that IQ test scores are only "approximations of conceptual functioning."[89] They theorized that "[r]elying solely on an IQ score at *any* level" is inadequate, and that "the appropriate method of diagnosis in every case is a comprehensive assessment of the individual's adaptive . . . functioning."[90] Yet the DSM-5 and AAIDD could not even agree on the definition and role of adaptive functioning. Nor did the DSM-5-TR adequately explain the justification for its revision and whether there is a new consensus on adaptive functioning.

---

[89] *Hall* APA Brief 16.
[90] *Id.* at 25 (emphasis added).

Fourth, elevating subjective opinions about adaptive functioning above intellectual function as evidenced by a string of IQ tests is suspect on a couple levels. This Court has said that "diminished *intellectual* functioning" "'make[s] it less likely that a defendant can process the information of the possibility of execution as a penalty' and therefore be deterred from committing murders." *Hall*, 572 U.S. at 737 (Alito, J., dissenting) (brackets omitted) (quoting *Atkins* v. *Virginia*, 536 U.S. 304, 320 (2002)). Even "[s]trong evidence of a deficit in adaptive behavior" (*ibid.*) could not alone show diminished *intellectual* functioning.

Plus, "adaptive behavior is a malleable factor without 'firm theoretical and empirical roots,'" and "its measurement relies largely on subjective judgments" based on memories from third parties. *Ibid.* "The evaluation of a person's adaptive functioning involves significantly more subjective clinical judgment" "than the assessment of IQ," since adaptive functioning determinations depend on "the selection of the tests used to assess adaptive behavior, the persons selected as informants, the conduct of the interviews, and the ultimate interpretation of the tests' results." *United States* v. *Hardy*, 762 F. Supp. 2d 849, 883 (E.D. La. 2010). These subjectivity problems are even worse "in the *Atkins* context where" adaptive functioning determinations "often are based on retrospective recollections of an individual's youth." *United States* v. *Wilson*, 170 F. Supp. 3d 347, 368 (E.D.N.Y. 2016). "[A]s the need for clinical judgment increases, so does the opportunity for disputes between clinicians" (*Hardy*, 762 F. Supp. 2d at 883)—and for some

putative expert to opine that an individual has adaptive deficits that preclude appropriate punishment.

For instance, Respondent's expert (and the district court) relied on tidbits from other people, including that Respondent in his 20s "wanted to fit in," "[d]idn't seem to cook food," "did not work consistently," and had "reckless behaviors." Pet. 87a; see also Pet. Reply 4 (collecting similar tidbits). That these facts could describe a substantial number of single men in their 20s only reinforces the subjectiveness of the adaptive functioning inquiry—and how easily it can be manipulated by those with some hostility toward the death penalty. That the APAs would want to tilt the inquiry toward this subjective determination aligns with their ideological opposition to the death penalty. Accord *Mays*, 686 S.W.3d at 750 n.1, 751 (Yeary, J., dissenting) (noting that "[t]he criteria for discerning a diagnosis of intellectual disability" have become "less rigorous" "with each successive manual").

In sum, the APAs have told this Court that there is scientific consensus about how to determine intellectual disability.[91] But that has always been suspect. The Court should not further "constitutionalize rules" based on a non-existent consensus by ideological interest groups. *Moore*, 581 U.S. at 31 (Roberts, C.J., dissenting).

---

[91] See, *e.g.*, *Moore* APA Brief 7–8.

III. States should not be required to follow the APAs' latest positions.

Even when it has overly deferred to medical interest groups, this Court has never obligated States to adopt their changing (and contradictory) understandings of intellectual disability. See, *e.g.*, *Hall*, 572 U.S. at 721 ("[T]he views of medical experts . . . do not dictate the Court's decision."). Rather, the "clearest and most reliable objective evidence" about what punishments may be cruel and unusual "is the legislation enacted by the country's legislatures." *Atkins*, 536 U.S. at 312. In no other area of criminal law is such authority delegated, and doing so would be impracticable and unworkable.

A. In no other area of criminal law is state authority over public policy confined by interest group positions.

In the Eighth Amendment context, 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). That is why "the States have, over the years, developed numerous specialized terms to define mental health concepts" even when those terms "do not fit precisely with the definitions employed by the medical community." *Ibid*. For instance, the legal definitions of "insanity" and "competency" "vary substantially from their psychiatric counterparts." *Ibid*. Thus, legal definitions "need not mirror those advanced by the medical profession." *Ibid.*

That has been true across criminal law. Take a defendant's competency to stand trial. "It has long

been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial." *Drope* v. *Missouri*, 420 U.S. 162, 171 (1975). The Court had admitted "uncertainty of diagnosis in this field and the tentativeness of professional judgment." *Id.* at 176. Yet the various DSMs do not contain a diagnosis that would determine whether a defendant is legally competent to stand trial.

In fact, the DSM-5 expressly disclaims the ability to decide questions like this, explaining that there is an "imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis." DSM-5, at 25; see DSM-5-TR, at 29. It also warns 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 (e.g., . . . disability)." DSM-5, at 25; see DSM-5-TR, at 29.

All this is unsurprising. While diagnostic manuals like the DSM are generally concerned with diagnosing patients to provide them appropriate treatments, the legal system is mainly concerned with other issues, like determining competency to ensure the defendant's "due process right to a fair trial." *Drope*, 420 U.S. at 172. The medical and legal definitions serve different purposes, notwithstanding the APAs' continual suggestions in their *amicus* briefs to this Court that their manuals' definitions should frame—

if not dictate—the contours of the Eighth Amendment.[92] And medical diagnoses only go so far: for instance, no "scientific analysis" could "possibly show that a mildly [intellectually disabled] individual who commits an exquisite torture-killing is 'no more culpable' than the 'average' murderer in a holdup-gone-wrong or a domestic dispute." *Atkins*, 536 U.S. at 350 (Scalia, J., dissenting).

Diagnostic manuals also did not play a controlling role when the Court upheld a narrow definition of the insanity defense in *Clark* v. *Arizona*, 548 U.S. 735 (2006). There, the Court distinguished "medical definitions [which are] devised to justify treatment" from "legal [definitions which are] devised to excuse from conventional criminal responsibility." *Id.* at 752. Likewise, in *Leland* v. *Oregon*, this Court explained that the "choice of a test of legal sanity involves not only scientific knowledge but questions of basic policy as to the extent to which that knowledge should determine criminal responsibility." 343 U.S. 790, 801 (1952).

When the Court considered whether "the Eighth Amendment permits the execution of a prisoner whose mental illness deprives him of the mental capacity to understand that he is being executed as a punishment for a crime," the Court did not base the inquiry on the medical diagnosis finding that the defendant suffered from severe delusions. *Panetti* v. *Quarterman*, 551 U.S. 930, 954 (2007) (cleaned up). Instead, the relevant "*legal* inquiry concern[ed] whether these

---

[92] See, *e.g.*, *Hall* APA Brief 25; *Moore* APA Brief 26.

delusions can be said to render him incompetent." *Id.* at 956 (emphasis added). In effect, a defendant meeting the diagnostic criteria for a psychotic disorder warranted no more than the "beginning of doubt about competence" *Id.* at 960.[93]

Thus, a mental defense has not and should not be restrictively bound to a clinical definition. And this Court need not "abandon[] the usual mode of analysis [it] has employed in Eighth Amendment cases." *Moore*, 581 U.S. at 21 (Roberts, C.J., dissenting). "[J]udges, not clinicians, should determine the content of the Eighth Amendment." *Id.* at 22. That determination should look to "the workings of normal democratic processes in the laboratories of the States," not the views of "private organizations speaking only for themselves." *Atkins*, 536 U.S. at 326 (Rehnquist, J., dissenting). "For this Court to uncritically adopt the latest expression of the apparent consensus of [a small slice of] the psychiatric community as to the appropriate diagnostic criteria for [intellectual disability], overinclusive though that expression may be," would "constitute[] an abdication of the Court's judicial role." *Mays*, 686 S.W.3d at 751 n.3 (Yeary, J., dissenting).

B. Forcing the States to follow the latest interest group positions would be impracticable.

In *Moore*, this Court said that "current manuals offer 'the best available description of how mental disorders are expressed and can be recognized by

---

[93] See generally *Moore* CJLF Brief 7–10 (making similar points).

trained clinicians.'" 581 U.S. at 20 (quoting DSM-5, at xli). As shown above, that claim is now dubious. The DSM-5 has been widely criticized by scholars, psychiatrists, and other medical groups. The same is true for its successor. The DSM-5 and AAIDD-11 manuals could not even agree on a single "best available description" of intellectual disability. Indeed, the AAIDD warned the American Psychiatric Association that "[h]aving the two most authoritative manuals in the country defining 'intellectual disability' using different terminology and different definitions would create havoc . . . in the courts (especially in death penalty cases)."[94]

As for the DSM-5-TR, it failed to clarify whether there is some newfound medical consensus on adaptive functioning. It only called its predecessor's definition of adaptive functioning "inadvertent." But this Court had relied on that supposed "inadvertent" term. See *Hall*, 572 U.S. at 712; *Moore*, 581 U.S. at 17.

The point is that requiring States to follow the latest positions of (disagreeing) medical interest groups leaves them in an impossible position. Surely the 50 States are not forced to rewrite their laws simply because an interest group backpedals on a prior diagnostic criterion without pointing to new evidence. Constitutional law should not be outsourced to self-interested, ideological medical interest groups—especially on so serious a matter as whether

---

[94] AAIDD, *Letter Regarding DSM-5 Draft Diagnostic Criteria for "Intellectual Developmental Disorder"* 2 (May 16, 2012), https://perma.cc/E5EV-C37E.

the People may appropriately punish a convicted murderer.

CONCLUSION

For these reasons, the Court should reverse.

Respectfully submitted,

DANIEL Z. EPSTEIN
America First Legal Foundation
611 Pennsylvania Ave. SE #231
Washington, DC 20003
(202) 964-3721
daniel.epstein@aflegal.org

CHRISTOPHER E. MILLS
Counsel of Record
Spero Law LLC
557 East Bay St. #22251
Charleston, SC 29413
(843) 606-0640
cmills@spero.law

Counsel for *Amicus Curiae*

AUGUST 11, 2025