DOCKET NO. S24G1299

IN THE SUPREME COURT
STATE OF GEORGIA

STATE OF GEORGIA,

Appellant,

v.

MICHELLE WIERSON,

Appellee.

Brief of the American Psychiatric Association, the American Academy of Psychiatry and the Law, and the Georgia Psychiatric Physicians Association as *Amici Curiae*

JUSTIN MOORE
Counsel for Amici Curiae
American Psychiatric Association
American Academy of Psychiatry and the Law
Georgia Psychiatric Physicians Association
Georgia Bar No. 118462
2813 Bolero Lane
Atlanta, Georgia 30341
470-781-0045
jtmooreattorney@gmail.com

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INTERESTS OF THE AMICI

The American Psychiatric Association, the American Association of Psychiatry and the Law, and the Georgia Psychiatric Physicians Association submit this brief in support of the Appellee. The Appellant is proposing a fundamental change in the way that insanity cases are adjudicated in the State of Georgia that could result in significant and far-reaching negative consequences.

American Psychiatric Association

With more than 38,000 members, the American Psychiatric Association (APA) is the nation's leading organization of physicians who specialize in psychiatry. The American Psychiatric Association has participated in numerous cases before the Supreme Court of the United States and State Supreme Courts. The American Psychiatric Association and its members have a strong interest in one of the core matters of forensic psychiatry: the relevance of serious mental disorders to criminal punishment. Recognizing that serious mental disorders can substantially impair an individual's capacities to reason rationally and to inhibit behavior that violates the law. The American Psychiatric Association supports recognition of an insanity defense broad enough to allow meaningful consideration of the impact of serious mental disorders on individual culpability. American

Psychiatric Association, *Position Statement on the Insanity Defense*, available at https://www.psychiatry.org/ getattachment/e4bc77c7-8a10-4d5fbbdcc642284cee-0e/Position-Insanity-Defens e.pdf (2007, last revised 2019).

American Academy of Psychiatry and the Law

The American Academy of Psychiatry and the Law (AAPL) has approximately 2,000 psychiatrist members dedicated to excellence in practice, teaching, and research in forensic psychiatry. *The AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense*, 42 J. Am. Acad. Psychiatry & L. S3 (2014 Supp.), provides practice guidance and assistance in the performance of insanity defense evaluations by forensic psychiatrists. AAPL has participated as an amicus curiae in, among other cases, *Kahler v. Kansas*, 140 S.Ct. 1021 (2020), *McWilliams v. Dunn*, 137 S. Ct. 1790 (2017); *Moore v. Texas*, 137 S. Ct. 1039 (2017); *Hall v. Florida*, 572 U.S. 701 (2014); and *Clark v. Arizona*, 548 U.S. 735 (2006).

Georgia Psychiatric Physicians Association

With more than 600 members, the Georgia Psychiatric Physicians Association (GPPA) is the Georgia District Branch of the American Psychiatric Association. The GPPA and its members have a strong interest in the conduct of

insanity evaluations, particularly as many forensic psychiatrists in Georgia who conduct insanity evaluations and testify on those issues are members of the GPPA. This case raises new issues about the insanity test that would potentially have major implications for the conduct of insanity evaluations by psychiatrists.

INTRODUCTION

A criminal responsibility determination is a complex undertaking. In a typical insanity trial, the trier of fact is presented with multiple expert witnesses who attempt to provide a view of the defendant's state of mind at the time of the offense. These experts review a large quantity of information, from details of the defendant's arrest to medical records and even accounts of the defendant's childhood. They review this information and apply psychiatric and psychological principles learned from years of study, training, and experience. They then endeavor to communicate their conclusions to the trier of fact in the clearest and most succinct way possible.

The State of Georgia has codified this process in an attempt to manage this complicated intersection of science, medicine, and the law. In this appeal, the Appellant seeks to radically alter the process of determining a defendant's sanity and criminal culpability. In essence, the Appellant argues for creating an entirely new analysis: Was the defendant willfully noncompliant with psychiatric medication, and did that result in his or her insanity at the time of the offense? The Appellant argues

that the trier of fact should be able to reject a defendant's insanity defense if there is evidence of willful noncompliance. This argument urges the expansion of the insanity analysis to include the issue of psychiatric medication noncompliance without considering the feasibility and consequences of this proposal. The Appellant is asking psychiatrists and this Court to open a Pandora's box of speculation, conjecture, and uncertainty that will undermine and possibly nullify the insanity defense.

In most cases, it will be impossible for psychiatric experts to answer the questions necessary to assist the trier of fact in conducting the Appellant's new analysis. The trier of fact would need to know definitively if a defendant was noncompliant with his or her medication, but there may not be a definitive answer to that question. Moreover, experts and triers of fact have no guidance in this analysis. Noncompliance is not defined in medicine or law, and the trier of fact has no framework to deal with this information. Finally, experts and triers of fact are now required to look at two points in time: the defendant's state of mind at the time of the offense and the defendant's state of mind at the time of the "willful" decision to discontinue medication. Putting aside the question of whether noncompliance can even be determined, simply analyzing whether the decision was "willful" would be a very lengthy and, in most cases, unreliable process. In short, the Appellant urges the adoption of an unworkable standard that has no foundation in the law and will

lead to confusing, inconsistent, and unjust results.

STATEMENT OF FACTS

On September 27, 2018, Ms. Michelle Wierson was driving a Volkswagen Tiguan near the intersection of South Candler Street and Midway Road in Decatur, Georgia. As she approached the intersection, her vehicle collided with another car, resulting in the death of a child passenger. The prosecution alleged that Ms. Wierson was operating her vehicle at an excessive speed and that the child's death was the result of her reckless driving. She is also alleged to have slightly injured a responding off-duty police officer by scratching him. She was charged with Homicide by Vehicle in the First Degree, Reckless Driving, and Battery. There was evidence that Ms. Wierson was exhibiting psychotic behaviors before, during, and after the accident occurred. She was evaluated by two psychiatrists, and both opined that she was not criminally responsible. It is essentially undisputed by the prosecution that Ms. Wierson met the statutory definition of insanity. However, there is a factual dispute as to whether or not Ms. Wierson was compliant with her recommended psychiatric treatment.

Prior to trial, the prosecution filed a motion in limine seeking to introduce evidence of willful medication noncompliance, arguing that Ms. Wierson's noncompliance with medication voluntarily created a delusion, which is the basis

for her insanity defense. The trial court judge, the Honorable Courtney L. Johnson, issued an order granting the prosecution's request to introduce such evidence. The defense filed an interlocutory appeal challenging that decision with the Georgia Court of Appeals. On June 25, 2024, the Georgia Court of Appeals ruled that evidence of a defendant's medication noncompliance is not relevant and is, therefore, not admissible in a criminal responsibility trial. This appeal resulted.

ARGUMENT

I. The issues surrounding a psychotic defendant's noncompliance with psychiatric medication are so complex that experts cannot reliably conclude the extent to which a defendant was noncompliant with medications and, if so, whether the defendant's noncompliance with medication was the proximate cause of the criminal act.

The Appellant's argument can be distilled down to the proposition that approximately five to six weeks before the incident, the Defendant made a conscious and voluntary choice to discontinue psychiatric medication and that the car accident can be causally linked to that willful decision. Setting aside the fact that medication noncompliance and causation are found nowhere in the criminal responsibility analysis as established by statute, the Appellant is proposing what appears to be a relatively simple and straightforward analysis. However, the issue of psychiatric medication compliance involves a number of complex questions, none of which are simply or easily computed in the manner proposed by the Appellant. Each of these

questions is likely to be difficult, and so the complexity would radically change the nature of the factual determinations necessary in raising an insanity defense.

A. There is no standard definition of noncompliance within medicine or law.

The implication of the Appellant's argument is that a defendant is responsible for his or her treatment and that he or she would be culpable for the consequences of noncompliance. We must assume that the Appellant does not argue that a defendant must perfectly follow his or her medication regimen without fail for the entirety of his or her treatment history. That would make the question of noncompliance quite an easy one to answer, but since people rarely, if ever, take their medication exactly as prescribed, it would lead to the absurd result that all defendants are noncompliant with medication.

There is no legal definition of medication noncompliance. Similarly, there is no simple medical definition. The Appellant's argument is predicated upon the misconception that medication noncompliance is easily defined and ascertained by the trier of fact. From a factual standpoint, the question of medication noncompliance is not a binary "yes or no" proposition but rather an issue of degrees. As psychiatrists, we know from experience that some patients miss an occasional dose of medication, while others skip doses more regularly (e.g., taking every other dose or every third). Some patients are prescribed several medications for a

condition and stop taking one while continuing the others. And, of course, some patients stop their medications entirely for a period of time or permanently. Which of those patients can be said to have been noncompliant?

The instant case presents just such a complex situation: multiple medications were prescribed, taken for a period of time, and then one was arguably discontinued. Assuming, for the sake of argument, that one of the medications was, in fact, discontinued, there are now a host of questions related to the discontinuation that arise and go unaddressed. It would be nearly impossible for a psychiatrist to opine with certainty (and for a trier of fact to conclude) that one missed medication out of a complex treatment regimen caused a defendant's state of mind at the time of the criminal offense.

B. In most cases, experts cannot reliably determine whether a defendant was noncompliant with his or her medication.

Whether a patient actually stopped a medication can be very difficult to determine in cases where the patient claims they were taking it appropriately. This is very different from cases involving voluntary intoxication, where the fact of voluntary intoxication is generally clear: for example, the person was observed drinking in a bar, symptoms of intoxication (*e.g.*, staggering gait, slurred speech) were clearly observed, or a blood or urine test showed a significant level of a drug. With psychotropic medications, these conditions generally do not apply: patients are

not typically observed when taking their medications, the presence of symptom exacerbation cannot be taken as evidence of noncompliance since symptoms often wax and wane, not all medications have clearly measurable blood levels, and blood levels of a drug can be difficult to interpret.

With regard to blood levels of medications, patients vary considerably in their metabolism, so a blood level cannot be closely correlated with dose unless the patient had prior measures of drug level when the dose was known. Even when prior drug levels are known, changes in metabolism (*e.g.*, in mania) or the food patients ingest can affect drug levels even when they are compliant. Furthermore, unlike alcohol or drugs of abuse, which predictably lead to intoxication in a predictably short time frame, the effects of medication are often delayed by days or weeks. Therefore, in many cases, how much of which medication a defendant actually took would be difficult to ascertain.

C. Psychiatric patients stop taking their medications commonly, but very rarely, if ever, with the intent to induce a delusional or psychotic mental state.

Psychiatric medication noncompliance is a very common issue. While studies vary in their exact numbers, they are consistent in finding that the incidence of noncompliance in patients with psychotic disorders is quite high, around 50%. *See* A. Semahegn, et al., *Psychotropic medication non-adherence and its associated*

factors among patients with major psychiatric disorders: a systematic review and meta-analysis, 9 Systematic Reviews (2020). Reasons for noncompliance vary widely. *See* R. J. Marrero, et al., *Psychological factors involved in psychopharmacological medication adherence in mental health patients: A systematic review*, 103 Patient Education & Counseling 2116 (2020) and U. Stentzel, et al., *Predictors of medication adherence among patients with severe psychiatric disorders: findings from the baseline assessment of a randomized controlled trial (Tecla)*, 18 BMC Psychiatry 155 (2018).

1) Lack of insight is the most common reason for medication noncompliance.

Lack of insight is a hallmark of psychotic disorders; most people diagnosed with these conditions do not believe they are ill. To hold an individual responsible for lack of insight when lack of insight is part of the illness is unreasonable. Lack of insight into their condition is part of the illness, not a volitional choice. If a defendant discontinued medication as a result of his or her mental illness, it would seem to follow that he or she should not be held responsible for the consequences. Studies have shown very high rates of lack of insight among those with psychotic illnesses. One study utilizing a large international sample found that over 90% of patients suffering from schizophrenia and over 40% of those suffering from psychotic depression lacked insight into their condition. *See* N. Sartorius, R. Shapiro, & A.

Jablensky, *The international pilot study of schizophrenia.* 11 Schizophrenia Bulletin 21, 31 (1974). More recent studies have continued to find very high rates of lack of insight and a resulting lack of treatment adherence in patients suffering from schizophrenia. *See* P.F. Buckley, D.A. Wirshing, P. Bhushan, J.M. Pierre, S.A. Resnick, & C.W. Wirshing, *Lack of insight in schizophrenia: impact on treatment adherence*. 21 CNS Drugs 129 (2007) and J. Kim, et al. *Insight and medication adherence in schizophrenia: An analysis of the CATIE trial*. 168 Neuropharmacology 107634 (2020).

Some patients experience paranoia, causing them to distrust their mental health providers. Some patients suffer delusions or hallucinations that affect their judgment. Still, others suffer disorganized and tangential thought processes that impair the simple activities of daily living, including taking medications. Moreover, even when patients are cognizant enough to make intelligent decisions regarding their medications, they are faced with the decision to maintain their treatment in the face of problematic side effects that are in some ways more debilitating than the mental health condition from which they suffer.

The Appellant uses the terms "willful" and "volitional" with regard to the proposed analysis of the defendant's medication noncompliance. The implication is that if a defendant has made a volitional decision to stop medication, he or she could be culpable, and the defense of insanity would not be available. The Appellant is

essentially proposing to insert another criminal responsibility analysis into the existing analysis. This second analysis would examine the defendant's state of mind at the time of the decision to discontinue psychiatric medication. Ascertaining the mental state of the defendant at the time of the medication noncompliance to determine the voluntariness of the decision to discontinue medication would be difficult at best. It would involve evaluating the defendant's statements about his or her mental state, most often without the types of collateral data that are typically present when conducting an evaluation of the defendant's mental state at the time of the criminal act (e.g., witness reports, police records, jail records, etc.). Moreover, the difficulty may be compounded by the fact that the decision to discontinue psychiatric medications may have been made months or even years prior to the criminal act.

2) Patients often have justifiable reasons for not taking medications, such as intolerable side effects and lack of access to treatment.

Psychotropic medications have a wide variety of common side effects and rare but significant adverse effects. When patients' symptoms are reduced, but they experience significant side effects, they may lower the dosage of their medication or take less than recommended in an attempt to minimize the bothersome side effects. Common side effects of antipsychotic medications include weight gain, elevated blood sugar and cholesterol levels, involuntary muscle movements, sedation,

constipation, and elevated hormone levels (e.g., prolactin). In rare cases, antipsychotic medications can cause permanent involuntary muscle movements, dangerously low white blood cell counts, and life-threatening fevers and muscle rigidity. These bothersome side effects, or even the fear of experiencing them, often lead to patients stopping or reducing their medications.

Additionally, defendants who suffer from debilitating mental disorders often have great difficulty obtaining consistent and proper mental health care. There is a nationwide shortage of mental health providers, and individuals with serious mental disorders often cannot access treatment despite their willingness to do so. This problem can be compounded by a lack of financial resources, which is often the case when individuals are unable to work steadily due to psychiatric disability. The reality is that indigent defendants often struggle to obtain any treatment whatsoever due to a lack of resources or the simple inability to locate care.

D. It is very difficult in many cases to determine if, and to what degree, a patient's noncompliance with psychiatric medications led to his or her mental state.

To allow the admission of evidence regarding noncompliance with medication in the hopes of determining if it was the proximate cause of a defendant's mental state in many cases would be largely a matter of speculation and conjecture. The Appellant proposes a linear cause-and-effect relationship between the

discontinuation of psychiatric medications and the defendant's mental state. The Appellant's argument assumes that a psychiatrist could be employed to discern, with at least reasonable medical certainty, whether discontinuing medication was the cause of his or her insanity. This assumption is mistaken. In reality, there are a number of intervening issues that frustrate the analysis to the point of becoming speculative at best and utterly false and misleading at worst. Unlike voluntary intoxication, where the drug effect is within hours of the intoxication, the effects of noncompliance with medication can be delayed by weeks or months. During the period of delay, many other events may occur, which makes the causal connection between noncompliance and the result difficult to ascertain with reasonable medical certainty.

1) In situations where multiple medications are prescribed, the effects of discontinuing one medication are difficult to assess.

Psychiatric medications react with one another and often work in a synergistic relationship to alleviate the symptoms of a mental disorder. Additionally, psychiatric medications may interact with other medications taken for other conditions. The balancing of these medications for therapeutic effect is difficult enough in its own right and is often determined by trial and error over a period of time. Attempting to pinpoint or attribute a patient's resulting symptoms to the absence of one drug is challenging at best. Was it the absence of that drug that caused the patient to develop

symptoms, or was it the waxing and waning of symptoms that is often seen in treating psychotic disorders?

2) Proper psychiatric medication management is a moving target.

The Appellant's argument presupposes that a defendant's adherence to prescribed medications will ensure his or her mental stability for as long as he or she remains compliant. However, in practice, the effectiveness of psychiatric medications on individuals can vary over time. While psychiatrists are knowledgeable about the general efficacy of medications, they often will not know the effectiveness of a drug on an individual until it is tried. Even when a medication is found to be effective initially for an individual, sometimes that medication will lose its effect over time. Moreover, the symptoms of mental health disorders can wax and wane irrespective of medications, necessitating additional medication adjustments to alleviate worsening symptoms. In some cases, psychiatrists will advise patients to discontinue their medications or lower the dosages if intolerable side effects emerge during the course of treatment.

The common and real need to adjust medication dosages due to natural fluctuations in symptoms and treatment-induced side effects raises more questions and difficulties with defining or identifying noncompliance. If a defendant does not recognize or report the loss of efficacy of his or her medication, is that willful

noncompliance? Consider the defendant who stops taking a medication due to debilitating side effects. Is that situation to be considered willful noncompliance?

E. The results of noncompliance with prescribed medication are generally not reasonably foreseeable.

Conducting a psychiatric assessment of whether medication noncompliance occurred and attempting to discern the foreseeable effects of that noncompliance would raise questions for which, in many cases, there would be no clear or reliable answers. While in some cases, a retrospective analysis may lead to a reasonable opinion about a causal chain of events, that does not mean that the result was reasonably foreseeable at the time of the noncompliance. Moreover, the Appellant's argument places no constraints on the period of time to be analyzed. As the time period between cessation of medication and the criminal act lengthens, the possible intervening causes of symptoms grow exponentially. In the instant case, if the Defendant did indeed discontinue some of her medications, foreseeing that she would have a delusion that would result in her driving recklessly in such a manner that it would lead to an accident seems very unlikely.

Unlike an evaluation of whether the defendant was insane at the time of the alleged criminal act, an evaluation of noncompliance could easily involve careful scrutiny of past recommendations for treatment, difficult to answer questions about the defendant's mental status while not taking medications over an extended period

of time, and difficult judgments regarding the connection between noncompliance and the mental state at the time of the offense. The complexity and uncertainty of these issues would likely significantly alter the nature of trials involving an insanity defense.

II. There is no clear framework or guidance for the trier of fact to determine what medication noncompliance is or how to incorporate this information into an insanity analysis.

Since there has been no other suggestion or alternative provided, it would appear that the Appellant offers an all-or-nothing proposition. If there has been medication noncompliance, then the trier of fact is free to reject the insanity defense altogether and convict the defendant. Even if an accurate determination of medication noncompliance and its effects could be ascertained by expert witnesses and presented to the trier of fact, the lack of guidance on what to do with that information will lead to inconsistent verdicts at best and utter injustice at worst.

A. Even if a psychiatrist could provide an opinion as to a defendant's compliance with medications, the trier of fact has no legal definition of noncompliance.

The Appellant's argument invites the trier of fact to interpret noncompliance in whatever way it sees fit. Would missing one dose of prescribed medication constitute noncompliance? What about one or two? Would a patient who refused to

take medication initially and later complied be considered noncompliant? What about a patient who was prescribed but never started taking psychiatric medications?

B. At what point does a defendant become culpable for noncompliance?

The Appellant's proposed analysis invites the trier of fact to improvise in determining what constitutes noncompliance, as well as how to incorporate that information into its verdict. They would be free to interpose their own values and morals in deciding to condemn or excuse a defendant's noncompliance. As stated above, the reasons for noncompliance are manifold and can be quite compelling. If a defendant makes a volitional choice to stop medication due to the risk of tardive dyskinesia or sudden cardiac death, is he or she culpable? Mental symptoms wax and wane. The Defendant, in this case, was diagnosed with bipolar disorder, a condition that typically fluctuates between episodes of relative normalcy, mania, and depression. How much effect on this fluctuation would be necessary to hold the defendant liable for inducing a psychotic state? How foreseeable would the psychotic state need to be? There are no clear answers to these questions and no guidance whatsoever for the trier of fact.

Because of all the uncertainties noted above, allowing evidence of medication noncompliance would, in many cases, cause a major change in how criminal responsibility is evaluated and determined at trial. One study using mock jurors to

ascertain the effects of such information found that jurors who were somewhat skeptical of the insanity defense prior to trial became considerably less likely to make a finding of insanity, and while they considered such evidence, they did so in such a way that suggested they were not following their duties as the triers of fact. *See* C. T. Parrott, et al., *Medication state at the time of the offense: Medication noncompliance, insight and criminal responsibility*, 36 Behavioral Sciences and & the Law 339 (2018). In Georgia, few defendants each year are found not guilty by reason of insanity. For the above reasons, allowing evidence related to medication noncompliance would likely reduce this number even further. These difficulties are well understood in the psychiatric literature. Even the article by Torry and Weiss, cited by the prosecution in its *Motion in Limine to allow admission of evidence on noncompliance*, recognizes these complexities and does ***not*** call for a general rule of considering evidence of noncompliance in insanity trials. Zachary D. Torry & Kenneth J. Weiss, *Medication Noncompliance and Criminal Responsibility: Is the Insanity Defense Legitimate?* 40 The Journal of Psychiatry & Law 219 (2012).

III. <u>There is no insanity statute in the State of Georgia or any other jurisdiction in the United States that contemplates noncompliance with prescribed medication as an issue that could void an insanity defense.</u>

The Georgia insanity statutes, O.C.G.A. §§ 16-3-2, 16-3-3, 17-7-130.1, and 17-7-131, address only a defendant's state of mind at the time of the offense.

O.C.G.A. § 16-3-4 (c) states that voluntary intoxication shall not be an excuse for any criminal act or omission. None of these statutes refer, in any way whatsoever, to medication noncompliance. This is consistent with the insanity statutes of all 50 states and the United States Federal Code. Only two states, Hawaii and Massachusetts, have case law that addresses this issue, and both courts have ruled that medication noncompliance should not be a factor in an insanity determination.[1] *Hawaii v. Eager*, 140 Haw. 167 (2017); *Commonwealth v. Shin*, 86 Mass. App. Ct. 381 (2014). The *Shin* Court noted the absurdity that could ensue if evidence of medication noncompliance were permitted. "Finally, we note that the Commonwealth's argument, taken to its logical extreme, could be used to argue that every mentally ill defendant who had ever taken helpful medication in the past, but discontinued it, was criminally responsible." 86 Mass. App. Ct. at 390. Both courts flatly rejected the argument that noncompliance with medication is tantamount to voluntary intoxication and ruled, as did the Georgia Court of Appeals, that the appropriate analysis was whether the defendant was criminally responsible at the time of the offense and nothing more. *Wierson v. State*, 372 Ga. App. 102 (2024). This position is consistent with standards for insanity defense evaluations

[1] The Appellant cites to *Bailey v. State* to support its proposed analysis. However, that case is not factually analogous in that the defendant was not being treated with antipsychotic medications, and the Court upheld the judge's decision not to charge the jury on the issue of a delusional compulsion. The Court stated in dicta that the defendant would not have an insanity defense if he "voluntarily and intentionally induced his delusion" by intentionally engaging in a "highly stressful confrontation." *Bailey v. State,* 249 Ga. 535 (1982).

promulgated by the American Academy of Psychiatry and the Law, the leading organization of U.S. Forensic Psychiatrists. American Academy of Psychiatry and the Law, *AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense*, 42 Journal of the American Academy of Psychiatry and the Law S3 (2014). Admitting evidence of noncompliance would be a major deviation from legal precedent and would disregard long-standing conventions and recommendations provided by experts in this field.

CONCLUSION

The Appellant seeks to carve out a new exception that could negate the use of an insanity defense for cases in which evidence of medication noncompliance exists. O.C.G.A. §§ 16-3-2, 16-3-3, 16-3-4, 17-7-130.1, and 17-7-131 clearly do not contemplate the consideration of any evidence related to medication noncompliance. There are no insanity statutes in any state in the United States or in federal law that address the issue. Georgia case law does not directly address the issue. Of the two states that have directly addressed the issue in case law, both have concluded that this evidence must be excluded. Thus, the Appellant's proposed exception is not supported by statute, case law, medicine, science, or logic. Moreover, the question of how noncompliance with medical advice or recommended treatment affects a determination of criminal responsibility for an offense committed by a mentally ill

person raises complex issues that threaten to overwhelm the adjudication of insanity defense cases.

The determination of noncompliance and its causal connection to an offense is fraught with difficulties that would most often lead to speculative opinions that could not reach the level of reasonable medical certainty. The admission of this type of evidence would open the door to boundless inquiries into the overall treatment and mental state of defendants from the date of their onset of symptoms to the date of offense. Additionally, any examination of the defendant's noncompliance with medication prior to the date of offense would require an analysis of the defendant's mental state at the time of the decision to discontinue medication to determine if that noncompliance was volitional. In other words, this would lead to insanity defenses within insanity defenses. Moreover, even if a psychiatrist could determine that the defendant discontinued medication, that it was willful or volitional, and that it was the proximate cause of the ensuing insanity, the trier of fact has no clear standards or framework to deal with that information. To allow noncompliance with medication to become an issue in insanity cases would be to break one of the foundations of criminal law and would represent a fundamental and far-reaching change in the adjudication of criminal responsibility. We strongly recommend it not be undertaken by this Court.

I hereby certify that this submission does not exceed the word count limit imposed by Rule 20.

Respectfully submitted this 5th day of February, 2025.

JUSTIN MOORE
Counsel for Amici Curiae
American Psychiatric Association
American Academy of Psychiatry and the Law
Georgia Psychiatric Physicians Association
Georgia Bar No. 118462
2813 Bolero Lane
Atlanta, Georgia 30341
470-781-0045
jtmooreattorney@gmail.com

CERTIFICATE OF SERVICE

I hereby certify that there is a prior agreement with the below listed parties to allow for service of filings in PDF format via email:

Attorneys for Appellant

Sherry Boston
District Attorney
Office of the Dekalb County District Attorney
556 N. McDonough Street, Suite 700
Decatur, Georgia 30030

Thomas L. Williams
Assistant District Attorney
Office of the Dekalb County District Attorney
556 N. McDonough Street, Suite 700
Decatur, Georgia 30030

Sam D'etremont
Assistant District Attorney
Office of the Dekalb County District Attorney
556 N. McDonough Street, Suite 700
Decatur, Georgia 30030

Ellie Harris
Assistant District Attorney
Office of the Dekalb County District Attorney
556 N. McDonough Street, Suite 700
Decatur, Georgia 30030

Attorneys for Appellee

Robert G. Rubin
Peters, Rubin, Sheffield, & Hodges, P.A.
2786 North Decatur Road, Suite 245
Decatur, Georgia 30033

Kristen W. Novay
Garland, Samuel, & Loeb, P.C.
3151 Maple Drive, N.E.
Atlanta, GA 30305

Respectfully submitted this 5th day of February, 2025.

JUSTIN MOORE
Counsel for Amici Curiae
American Psychiatric Association
American Academy of Psychiatry and the Law
Georgia Psychiatric Physicians Association
Georgia Bar No. 118462
2813 Bolero Lane
Atlanta, Georgia 30341
470-781-0045
jtmooreattorney@gmail.com

EXHIBIT

ORDER GRANTING EXTENSION OF TIME TO FILE

AMICUS CURIAE BRIEF

SUPREME COURT OF GEORGIA
Case No. S24G1299

January 8, 2025

THE STATE v. MICHELLE WIERSON.

The request of the Georgia Psychiatric Physicians Association for an extension of time to file an amicus brief in support of Appellee in the above case is granted until February 6, 2025.

A copy of this order MUST be attached as an exhibit to the document for which you received this extension.

SUPREME COURT OF THE STATE OF GEORGIA
Clerk's Office, Atlanta

I certify that the above is a true extract from the minutes of the Supreme Court of Georgia.
Witness my signature and the seal of said court hereto affixed the day and year last above written.

, Clerk