IN THE COURT OF APPEALS OF GEORGIA

CASE NO. A24A0241

MICHELLE WIERSON,

Appellant,

v.

STATE OF GEORGIA,

Appellee.

On Appeal from the Superior Court of Dekalb County
Case No. 19CR1516

Brief of Georgia Psychiatric Physicians Association as *Amicus Curiae*

JUSTIN MOORE
GA Bar No. 118462
2813 Bolero Lane
Atlanta, Georgia 30341
470-781-0045
jtmooreattorney@gmail.com

TABLE OF CONTENTS

TABLE OF AUTHORITIES

AMICUS AND ITS INTEREST

The Georgia Psychiatric Physicians Association (GPPA), with more than 600 members, is the Georgia District Branch of the American Psychiatric Association. The GPPA 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. The conduct of insanity evaluations has received considerable attention from professional organizations. *See* 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 (2014); American Psychiatric Association, Position Statement on the Insanity Defense, available at https://www.psychiatry.org/getattachment/e4bc77c7-8a10-4d5f-bbdc-c642284cee0e/Position-Insanity-Defense.pdf (2007, last revised 2019). This case raises new issues about the insanity test that would potentially have major implications for the conduct of insanity evaluations by forensic psychiatrists.

STATEMENT OF THE CASE

The following summary is based on various legal documents filed in this case (Petitioner's Motion in Limine to Bar Inadmissible Evidence and Argument

of Medical Noncompliance; Respondent's Motion in Limine to Determine Pretrial Admissibility of Medication Noncompliance; and Judge Johnson's signed Order Granting State's Motion in Limine Regarding the Introduction of Evidence Related to Medication Noncompliance). The Appellant, Michelle Wierson, has suffered from bipolar disorder which was first diagnosed in 2005. On September 27, 2018, she was psychotic, drove very fast, and collided with another car, killing a child passenger. She was charged with Homicide by Vehicle in the First Degree, Reckless Driving, and Battery. Two psychiatrists have written reports opining that Ms. Wierson was not criminally responsible at the time of the offense. The reports did not address whether the defendant had been compliant with her medications.

The state sought to introduce evidence of willful medication noncompliance; arguing that noncompliance voluntarily created the delusion which is the basis for the Defendant's insanity defense. The trial court judge, the Honorable Courtney L. Johnson, issued an order granting the State's request to introduce such evidence. There is a factual dispute as to whether the defendant was noncompliant with her recommended treatment. The defense is appealing the judge's order.

SUMMARY OF ARGUMENT

1. The Georgia law regarding insanity and the insanity laws of other U.S. jurisdictions, do not contemplate noncompliance of taking prescribed

medication as an issue that could void an insanity defense.

2. **The ethical standards under which a defendant's lack of medication adherence should increase his or her criminal responsibility are unclear.**

3. **The factual determination of noncompliance and its relevance to criminal responsibility would be highly speculative and be very difficult to determine in many cases in which an insanity defense is raised. The issue is not analogous to ascertaining whether an individual became voluntarily intoxicated.**

4. **Because of the above three factors, allowing evidence of noncompliance with recommended medication would markedly change the nature of the adjudication of insanity cases in a way that would leave the finder of fact struggling with applying difficult-to-ascertain facts to unclear standards.**

ARGUMENT

1. The Georgia law regarding insanity and the insanity laws of other U.S. jurisdictions, do not consider noncompliance with medication as an issue that could void an insanity defense.

The argument raised by the state in this case is a matter of first impression

for Georgia Law. It is also a matter of first impression for most other jurisdictions. The Georgia insanity statutes, O.C.G.A. §§ 16-3-2 and 16-3-3, address the 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. There is no explicit provision that noncompliance with prescribed medication should be considered in determining a defendant's criminal responsibility. This is consistent with other jurisdictions. Two states have specifically addressed this issue and considered whether noncompliance should be a factor in an insanity determination. *Hawaii v. Eager*, 140 Haw. 167 (2017); *Massachusetts v. Shin*, 86 Mass. App. Ct. 381 (2014). Like Georgia, the insanity statutes of these states did not address the issue of medication noncompliance. The Supreme Court of Hawaii and the Massachusetts Court of appeals have ruled that such evidence should not be considered. This position is consistent with standards for insanity defense evaluations promulgated by the American Academy of Psychiatry and the Law. American Academy of Psychiatry and the Law, *AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense*, Journal of the American Academy of Psychiatry and the Law 42 (2014). Admitting evidence of noncompliance would be a major deviation from legal precedent and would disregard long-standing convention and recommendations provided by experts in this field.

2. The ethical standards under which a defendant's lack of medication compliance should increase his or her criminal responsibility are unclear.

While there are instances in which medication noncompliance would seem to affect criminal responsibility, in many cases the ethical question is unresolved. These questions turn on such issues as the patient's insight into his or her condition, the foreseeability of future dangerous action, and the duty a patient has to keep others safe. For example, at one end of the continuum, if a patient has a clear history of violence towards others when untreated and has insight into his or her condition, then knowingly discontinues medication for no rational reason, arguably that patient bears some responsibility for later violence. However, in less clear-cut cases, the ethical connection is less clear. How foreseeable should the risk to others be? Patients do not generally have a duty towards others to take medications. Consider a patient with no history of violence who is having side effects from a medication, and whose symptoms have been relatively stable. If the patient then discontinued several doses of medication and subsequently had a partial relapse that led to diminished attention while driving, how does one weigh the patient's autonomy to reduce medication to avoid side effects against a risk of symptom increase that carries with it some increased risk to others that is not foreseeable and difficult to quantify? There are no clear standards for answering

these questions, so the finder of fact, even if the facts were clear, would need to make these ethical judgments on his or her own.

3. The factual determination of noncompliance and its relevance to criminal responsibility is very difficult and highly speculative in many cases. The issue is not analogous to ascertaining whether an individual became voluntarily intoxicated.

To allow the admission of evidence regarding noncompliance with medication would be to open a Pandora's box of speculation and conjecture.

a. It is not clear what would constitute noncompliance. Would missing one dose constitute noncompliance? What about a patient who refused to take medication initially and later complied? Would the fact that a physician prescribed a medication, even when a patient initially did not consent, constitute noncompliance? Patient autonomy is a significant value: there are relatively few situations in which patients can be involuntarily medicated.

b. Whether a patient actually stopped a medication could be very difficult to determine in cases where the patient claimed they were taking medication appropriately. In cases involving voluntary intoxication, 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, slurring speech) were clearly observed, or a blood or urine test showed a significant level of drug. With psychotropic medications, these conditions generally do not apply: patients aren't typically observed when taking their medications, the presence of symptom exacerbation cannot be taken as evidence of noncompliance since symptoms often wax and wane, 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.,*mania) or the food patients ingest (*e.g.,*grapefruit) can affect drug levels even when a person is compliant. Furthermore, unlike alcohol or drugs of abuse which predictably lead to intoxication in a predictable short time frame, the effects of medication are often delayed by days. Therefore, in many cases, the impact of partial noncompliance is a speculative opinion that would not reach the level of reasonable medical certainty.

c. Patients may be noncompliant with medication recommendations for many reasons. 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*, Systematic Reviews 9 (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, Patient Education & Counseling 103 (2020); 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)*, BMC Psychiatry 18 (2018). Many patients with severe mental illness lack insight into their condition as a component of their illness. To hold a patient responsible for lack of insight when lack of insight is part of the illness is unreasonable. Other patients may think it justifiable to reduce their medication if their symptoms improve to see if they can do without them, particularly if they have unpleasant side effects from the medication. Psychotropic medications frequently have a wide variety of side effects.

The insane often do not know that they are insane. Any defendant that would meet the definition of insanity in this and most other jurisdictions

would not be able to differentiate between right and wrong or control his or her actions. If the Court were to accept the state's argument, a defendant would be required to adhere to a strict medication regimen despite him or her possibly being insane at that time.

d. The results of noncompliance with prescribed medication are generally not reasonably foreseeable. Unlike voluntary intoxication, where the drug effect is within hours of the intoxication, the effects of noncompliance with medication can be quite delayed. 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. 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. Mentally ill patients who do not abuse substances have been shown not to have higher rates of violence than the general population, so unless the patient has a clear history of violence while un-medicated, it is not generally reasonably foreseeable that they would become violent in the future. *See* Henry J. Steadman, et al., *Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, Archives of General Psychiatry 55

(1998). In the instant case, it seems unlikely that it was reasonably foreseeable that the defendant would have a delusion that would result in driving recklessly in such a manner that it would lead to an accident.

e. The extent to which evidence of noncompliance with medication reduces criminal responsibility raises numerous ethical questions about the nature of criminal responsibility that are unresolved. These include such issues as liability for acts of omission, the extent to which the offense was reasonably foreseeable at the time of the noncompliance, and the extent to which a mentally ill person should be held liable for errors of judgment when the mental illness itself affects judgment. These ethical questions are not medical questions, but without a clear ethical framework that would address these issues, the relevance of medical information is difficult to ascertain.

4. Allowing evidence of noncompliance with recommended medication would markedly change the nature of the adjudication of insanity cases in a way that would leave the finder of fact struggling with applying difficult-to-ascertain facts to unclear standards.

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*, Behavioral Sciences and & the Law 36 (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 ever further. These difficulties are well understood in the psychiatric literature. Even the article by Torry and Weiss, cited by the state 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?* The Journal of Psychiatry & Law 40 (2012).

CONCLUSION

The state is seeking to carve out a new exception that would possibly prohibit the use of an insanity defense for cases in which evidence exists of

medication noncompliance. O.C.G.A. §§ 16-3-2 and 16-3-3 clearly do not contemplate the consideration of any evidence related to medication noncompliance. There are no insanity statutes present in any state in the United States that address the issue. Georgia case law does not address the issue. Of the two states that have addressed the issue in case law, both have come to the conclusion that this evidence must be excluded. Thus, this 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. There is no consensus on the ethical framework for weighing such evidence. The determination of noncompliance and its causal connection to an offense is fraught with difficulties that would often lead to speculative opinions that would 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 that time of noncompliance to see if he or she were culpable. In other words, this would lead to insanity defenses within insanity defenses. 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. It should not be undertaken by this Court.

Respectfully submitted this 26th day of October, 2023.

I hereby certify that this *Amicus Curiae Brief* was created using Times New Roman 14-point font and does not exceed the word count limit imposed by Rule 24.

JUSTIN MOORE
GA Bar No. 118462
Counsel for Amicus Curiae
2813 Bolero Lane
Atlanta, GA 30341
470-781-0045
jtmooreattorney@gmail.com

CERTIFICATE OF SERVICE

I hereby certify that I have this day served the below-listed parties, by and through counsel, in the foregoing matter with a copy of the foregoing *Brief of Georgia Psychiatric Physicians Association as Amicus Curiae* by delivering a copy via United States mail with postage pre-paid to the following:

Attorneys for Appellee
Thomas L. Williams, Josh Gellar, and Shannon Hodder
Assistant District Attorneys
Dekalb County District Attorney's Office
556 N. McDonough Street, 7th Floor
Decatur, Georgia 30033

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

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

This 26th day of October, 2023.

JUSTIN MOORE
GA Bar No. 118462
Counsel for Amicus Curiae
2813 Bolero Lane
Atlanta, GA 30341
470-781-0045
jtmooreattorney@gmail.com