Case No. A21A0490

Court of Appeals of Georgia

In the interest of T.B., a child

AMICUS CURIAE BRIEF OF BARTON CHILD LAW & POLICY CENTER OF EMORY UNIVERSITY SCHOOL OF LAW, LORIO FORENSICS AND DR. SARAH Y. VINSON IN SUPPORT OF T.B., A CHILD

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I. INTEREST OF THE AMICI CURIAE

Amici curiae respectfully submit this *amicus* brief pursuant to Rule 23 and urge this Court to recognize the applicability of the affirmative defense of insanity, including delusional compulsion, in Georgia's juvenile courts.

The Barton Child Law and Policy Center ("Barton Center") is a clinical program of Emory University School of Law dedicated to promoting and protecting the legal rights and interests of children involved with the juvenile court, child welfare, and juvenile justice systems in Georgia. The Barton Center achieves its reform objectives through research-based policy development, legislative advocacy, and holistic legal representation for individual clients. The Barton Center adopts a multidisciplinary, collaborative approach to achieving justice for youth through which children are viewed in their social and familial contexts and provided with individualized services to protect their legal rights, respond to their human needs, and ameliorate the social conditions that create risk of system involvement.

The Barton Center was founded in March 2000. Its work is directed by Emory Law faculty and performed by law and other graduate students who advocate for children through participation in the Policy and Legislative Advocacy Clinics, the Juvenile Defender Clinic, and the Appeal for Youth Clinic. Under the supervision of experienced faculty members, students represent children in juvenile delinquency, special education, and school discipline cases and seek post-conviction relief for

youthful offenders in criminal matters. Students also engage in legislative and policy advocacy on issues impacting vulnerable children. The Barton Center has represented more than 400 youth and trained nearly 1,000 students who now serve in leadership positions in nonprofit organizations, state and local government agencies, and private firms.

Legal services provided by the Barton Center are provided at no cost to our clients. The work of the Barton Center is funded by Emory Law School, private gifts, foundation grants, and contracts with a variety of organizations.

Through participation as *amicus curiae*, the Barton Center hopes to provide a voice for T.B. and for those similarly situated who will be directly and profoundly affected by the Court's decision.

Lorio Forensics is an interdisciplinary group of mental health professionals who maintain active clinical practices while also providing forensic mental health consultation services in family, civil, and juvenile courts in many states including Georgia. Lorio Forensics renders its services from a strong theoretical and clinical foundation in the fields of social work, psychology, and psychiatry. Lorio Forensics adopts a scientifically-based, culturally, and structurally informed approach to consulting, evaluation, writing, and testimony. Its forensic mental health consultants have served on national committees of multiple national professional organizations including the American Academy of Child and Adolescent Psychiatry, The

American Association of Community Psychiatrists, and the American Psychological Association.

Through participation as *amicus curiae*, Lorio Forensics hopes to assist the Court in taking a scientifically, psychologically, and neurodevelopmentally informed approach in its consideration of juvenile insanity.

Sarah Y. Vinson, M.D. is a triple board certified child & adolescent, adult and forensic psychiatrist who maintains an active clinical practice, holds faculty appointments at Morehouse School of Medicine and Emory School of Medicine, and is the Principal Consultant at Lorio Forensics, which provides forensic mental health consultation services in family, civil, and juvenile courts in many states including Georgia. Dr. Vinson completed post-graduate training at Harvard Medical School and Emory University and is currently an Associate Professor of Psychiatry and Pediatrics and the Program Director for the Child & Adolescent Psychiatry Fellowship at Morehouse School of Medicine. She has co-edited two books and co-authored several book chapters and articles in peer-reviewed publications.

Dr. Vinson has served on national committees of multiple national professional organizations including the American Academy of Child and Adolescent Psychiatry, The American Association of Community Psychiatrists, and the American Psychiatric Association. She was appointed to the Governor's Behavioral Health Reform and Innovation Commission by the Governor and chosen

by the commission's chair to head the Child and Adolescent Subcommittee. Dr. Vinson hopes to assist the Court in taking a clinically, psychiatrically informed approach in its consideration of juvenile insanity.

II. SUMMARY OF THE ARGUMENT

Mental illness is not a disease reserved for the mature and developed mind. It does not lie in wait for one's 18th birthday. It does not ask for an I.D. before entering the mind. It does not discriminate based on age. Mental illness is an equal-opportunity disease that preys on youthful minds in the same way it preys on adults.

If adults can raise an affirmative defense of insanity, it is capricious to disallow juveniles that same opportunity. Doing so robs those most vulnerable, psychologically impaired children from the most logical defense for their circumstances. It exposes them to punishment that is neither tailored to their person nor just in its administration. It is imperative for the Court to rectify this oversight and extend this dispositive safeguard to juveniles.

III. ARGUMENT

A. A Finding of *Mens Rea* is Fundamental to a Juvenile Court Delinquency Adjudication

To be found guilty of a crime in adult court, a defendant must have done the criminal act, *actus reus*, with criminal intent, *mens rea*. O.C.G.A. § 16-2-1(a). The *mens rea* requirement does not vanish simply because a defendant is in juvenile court. In fact, this Court has expressly identified the applicability of the *mens rea*

requirement in juvenile court adjudication hearings. *See, e.g., In the Interest of I.M.W.*, 313 Ga. App. 624, 626 (2012) (applying the *mens rea* requirement within the Anti-Mask Act to the delinquency adjudication of a juvenile defendant); *M.J.W. v. State*, 133 Ga. App. 350, 351 (1974) (explicitly discussing the element of *mens rea* in upholding a juvenile delinquency adjudication for criminal trespass).

Notably, many statutes themselves have incorporated an explicit intent element into the very description of the criminal act. *See, e.g.*, O.C.G.A. § 16-8-18 (entering an automobile with the intent to commit a theft or a felony); O.C.G.A. § 16-13-30(b) (possession of a controlled substance with the intent to distribute); O.C.G.A. § 16-4-1 (criminal attempt is when a person, with intent to commit a specific crime, performs any act which constitutes a substantial step toward the commission of that crime); O.C.G.A. § 16-5-21(a)(1) (aggravated assault with intent to murder, to rape, or to rob); O.C.G.A § 16-7-88 (possessing, transporting, or receiving explosives, etc. with intent to kill, injure, etc.). Where the statute has established such a mandate, it is axiomatic that the evidence demonstrate the requisite *mens rea* before a court can adjudicate a juvenile as delinquent. *See In the Interest of C.S.*, 251 Ga. App. 411, 412–13 (2001) (explaining juvenile could not be adjudicated for criminal attempt because no evidence existed from which an intent to commit the underlying offense, battery, could be inferred).

Even where there is no explicit element of intent in a criminal statute, intent has been required to prove an offense. *See In the Interest of E.B.*, 343 Ga. App. 823, 825 (2017) (reversing a juvenile court adjudication where there was insufficient evidence which could "evince an intent to appropriate the item"); *In the Interest of C.L.*, 289 Ga. App. 377, 379 (2008) (vacating a juvenile court adjudication because the child was merely present during the crime, and a juvenile must "intentionally" aid or abet its commission or "intentionally" help someone to commit the crime).

Because a finding of criminal intent is a necessary predicate to a juvenile delinquency adjudication, the option to raise the insanity defense logically follows.

B. Mental Illness, and Therefore Insanity, is Not Exclusive to Adults

Severe, persistent mental illnesses can start, and can greatly impact judgment and behavior, during childhood and adolescence. Given the prevalence of mental illness in youth and the myriad of impairments caused by these disorders from a clinical, psychological, and neurodevelopmental perspective, the insanity defense is just as applicable to children and adolescents as it is to adults.

1. Prevalence of Schizophrenia and Psychotic Symptoms in Children and Adolescents

Descriptions of criminal insanity, and adolescent insanity, predate the creation of the juvenile court; the term "adolescent insanity" was first coined in 1873. P. O'Connell et al., *Developmental insanity or dementia praecox: was the wrong concept adopted?*, 23 Schizophrenia Research 97–106, 97 (1997). The term

"schizophrenia" was initially coined in 1908. Jon McClellan et al., *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia*, 52 J. of the Am. Acad. of Child & Adolescent Psychiatry 976–90, 977 (Sept. 2013).

Psychotic symptoms – disruption of thoughts, emotions, and behaviors – can manifest in children, adolescents, and adults as a result of three causal pathways: (a) through a formal mental illness diagnosis of schizophrenia or other mental disorders; (b) without a formal mental illness diagnosis through a separate physical ailment which manifests into psychotic symptoms; or (c) as a result of side effects of prescription drugs.

a) Psychotic Symptoms
Within a Mental Illness Diagnosis

Psychotic symptoms are primarily associated with the diagnosis of schizophrenia and other psychotic disorders. Psychotic symptoms are the quintessential symptoms of schizophrenia. These symptoms substantially impair overall function and influence children and adolescents in many ways. The World Health Organization estimates twenty million people present with schizophrenia. McClellan, *supra*, at 977. The onset of schizophrenia typically occurs between the ages of 14–35 years, with half of the cases occurring before 25 years. *Id.* Specific to the United States, schizophrenia and other related psychotic disorders occur within 0.25% and 0.64% of the population. *Id.* Although schizophrenia was originally

studied as a mental illness suffered by adults, it has long been recognized as a disease that impacts children and adolescents. Jennifer Bartlett, *Childhood-onset schizophrenia: what do we really know?*, 2 Health Psychol. & Behav. Med. 735–47, 735 (Apr. 5, 2014); Susan K. Schultz et al., *The life course of schizophrenia: age and symptom dimensions*, 23 Schizophrenia Research 15–23, 16 (Aug. 9, 1997).

Schizophrenia in children has been characterized as either early onset schizophrenia ("EOS") or childhood onset schizophrenia ("COS"). EOS occurs when an individual is diagnosed before age 18. McClellan, *supra*, *at* 977. Rarer is COS, where diagnosis occurs before 12 years of age *Id.* Although both EOS and COS mirror adult schizophrenia neurobiologically, EOS and COS are more severe. *Id.* at 978.

Regardless of age, schizophrenia is diagnosed similarly. The DSM-5 requires two or more of the following symptoms occur for at least one month: hallucinations, delusions, disorganized speech, disorganized or catatonic behavior, and/or negative symptoms. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 87, 122 (eds. William T. Carpenter Jr., Deanna M. Barch, Juan R. Bustillo, Wolfgang Gaebel, Raquel E. Gur, Stephan H. Heckers, Dolores Malaspina, Michael J. Owen, Susan K. Schultz, Rajiv Tandon, Ming T. Tsuang, Jim van Os, 5th Ed. 2013). Further, evidence of schizophrenia must be present for at least six months and be associated with a significant decline in social or occupational

functioning. *Id*. In children and adolescents, decline in functioning may include changes in social functioning, academic growth, or the failure to achieve age-appropriate levels of development; functioning does not need to actually decline, but rather not progress based on developmental trajectory. *Id.*

Psychotic symptoms are also present in other psychiatric disorders. These disorders include depression, bipolar disorder, autism spectrum disorder, or dissociative states associated with trauma. Ann E. Maloney et al., *Empirical evidence for psychopharmacologic treatment in early-onset psychosis and schizophrenia*, 21 Child & Adolescent Psychiatry Clinics of N. Am. 885–909, 886 (2012); Jonathan R. Stevens et al., *Psychotic disorders in children and adolescents: a primer on contemporary evaluation and management*, 16 Primary Care Companion for CNS Disorders 1–14, 1 (Mar. 13, 2014). For example, studies suggest 40-60% of bipolar youth have psychotic symptoms and 15-35% of depressed adolescents present psychotic symptoms. *See* Armand W. Loranger & Peter M. Levine, *Age at onset of bipolar affective illness*, 35 Archives of General Psychiatry 1345-48 (Apr. 20 1978); Ann E. Maloney, *supra*, at 886. *See also* Gabrielle A. Carlson & Javad H. Kashani, *Manic symptoms in a non-referred adolescent population*, 15 J. of Affective Disorders 219–26, 219 (May 18, 1988); William J. Chambers et al., *Psychotic symptoms in prepubertal major depressive disorder*, 39 Archives of General Psychiatry 921–27, 921 (Aug. 1982); Niel D. Ryan & Joaquim

Puig-Antich, *Pharmacological treatment of adolescent psychiatric disorders*, 8 J. of Adolescent Health Care 137–42, 137–38 (1987).

b) Psychotic Symptoms Outside a Formal Mental Illness Diagnosis

A formal diagnosis of mental illness is not necessary for children and adolescents to experience psychotic symptoms. Some physical ailments can result in psychotic symptoms. For example, numerous genetic syndromes, inborn errors of metabolism, auto-immune, neurological, endocrinological, and nutritional disorders can increase the risk of psychotic disorders in childhood and adolescence. Marianna Giannitelli et al., *An overview of medical risk factors for childhood psychosis; implications for research and treatment*, 192 Schizophrenia Research 39–49, 44 (May 16, 2017). A study that compared the psychiatric diagnoses of 49 youths with Down syndrome to 70 individuals with other intellectual disabilities found that 35% of individuals with Down syndrome had psychotic symptoms when compared with 13% of individuals in the group with other disabilities. Elisabeth M. Dykens, et al. *Psychiatric disorders in adolescents and young adults with Down syndrome and other intellectual disabilities*, 7 J. of Neurodevelopmental Disorders 1–8, 1 (2015).

Psychotic symptoms can also occur without a mental health diagnosis or through a physical ailment. The prevalence rate of psychotic symptoms alone is 5–8% in the general population – a rate nearly 10 times higher than the prevalence of diagnosed psychotic disorders. Jim van Os et al., *A systematic review and meta-*

analysis of the psychosis continuum: evidence for a psychosis-proneness-persistence-impairment model of psychotic disorder, 39 Psychol. Med. 1–17, 5–6 (May 12, 2008). A study of psychotic symptoms among children and adolescents found that a median of 17% of 9 to 12-year-olds and 7.5% of 13 to 18-year-olds reported psychotic symptoms in childhood and adolescence. Ian Kelleher et al., *Prevalence of psychotic symptoms in childhood and adolescence: a systematic review and meta-analysis of population-based studies*, 42 Psychol Med 1857–63, 1859 (Jan. 9, 2012).

c) Psychotic Symptoms as a Result of Side Effects of Prescription Drugs

Prescribed medications can also induce psychotic side-effects. In 2007, after small trials suggested a causal relationship amongst stimulant use and psychosis, the Food and Drug Administration required manufacturers of stimulants to add a warning to drug labels that "stimulants may cause treatment-emergent psychotic or manic symptoms in patients with no prior history." Lauren V. Moran et al., *Psychosis with Methylphenidate or Amphetamine in Patients with ADHD*, 380 New England J. of Med. 1128–38, 1128 (Mar. 21, 2019).

Additionally, medications used to treat both medical and psychiatric illnesses can induce psychotic symptoms. These medications include corticosteroids (used for treatment of inflammatory conditions or infections), isotretinoin (used for treatment of acne), interferon-a (used for treatment of viral and immune conditions, as well as

cancer), and psychotropic medications (such as antidepressants, anxiolytics, antipsychotics, or mood-stabilizers). Rodrigo Casagrande Tango, MD., *Psychiatric side effects of medications prescribed in internal medicine*, 5 Dialogues in Clinical Neuroscience 155–65, 155 (2003).

2. Psychotic Symptoms and their Practical Effects on Children and Adolescents

Schizophrenia leads to impairments and deficits that are highly correlated with poor functioning and compromised judgment. Most individuals with schizophrenia experience warning signs through some degree of functional deterioration or the stalling of functional progression before the onset of psychotic symptoms, known as the prodromal phase. Of children ages thirteen and above with onset of schizophrenia, 67% show early disturbances in social, motor, and language domains, as well as learning disabilities. David I. Driver et al, *childhood-onset schizophrenia and early onset schizophrenia spectrum disorders: an update*, 22 Child and Adolescent Psychiatric Clinics of N. Am. 71–90, 73 (Oct. 2020).

Children and adolescents suffer from both typical schizophrenic symptoms and unique, age related symptoms. Typical symptoms of schizophrenia include hallucinations, delusions, incoherent speech, meaningless repetition of speech, neologisms, disorganized and illogical thought processes, and difficulty generating thoughts. Children with schizophrenia also demonstrate a failure to develop age-appropriate communication skills and suffer from marked social deficiencies. Carrie

E. Bearden et al., *Thought disorder and communication deviance and predictors of outcome in youth in clinical high risk of psychosis*, 50 J. of the Am. Acad. of Child & Adolescent Psychiatry 669–80, 678 (July 2011). In cases of EOS, children can experience withdrawal and isolation, idiosyncratic or bizarre preoccupations, unusual behaviors, academic failure, deteriorating self-care skills, and mood changes. John L. Schaeffer & Randal G. Ross, *Childhood-onset schizophrenia: premorbid and prodromal diagnostic and treatment histories*, 41 J. of the Am. Acad. of Child & Adolescent Psychiatry, 538–45, 542 (May 2002); McClellan, *supra*, at 979. The symptoms of schizophrenia produce deficits that are highly correlated with poor functioning and compromised judgment. Stevens, *supra*, at 3. Compared to adults, children and adolescents are more likely to be emotionally over-reactive or demonstrate distress due to a relatively limited understanding of their illness or their symptoms which further compromises their judgment. *Id.*

3. Etiology of Schizophrenia

Although previously focused on adult subjects, there is a growing research drawing upon neuroimaging studies in the child and adolescent populations.

In adults with schizophrenia, magnetic resonance imaging ("MRI") studies have shown reduced brain matter in the parts of the brain responsible for memory, auditory information processing, and decision making. Nitin Gogtay & Judith L. Rapoport, *Childhood-onset schizophrenia: insights from neuroimaging studies*,

47(10) J. Am. Academy Child Adolescent Psychiatry, 1120–21, 1123, (2008); Driver, *supra*, at 77–79.

Neuroimaging studies have shown that adults with first episode or chronic schizophrenia have significant white matter[1] abnormalities which affect the transmission of information in the brain. The deficiency of white matter development occurs during adolescence and early adulthood, which is the time period most associated with the onset of psychosis. Sarah Jacobson et al., *Structural and functional brain correlates of subclinical psychotic symptoms in 11–13 year old schoolchildren*. 49(2) NeuroImage, 1875–85, 1876 (2010).

Myelination is a natural process occurring through late adolescence, which enables the brain to transmit information efficiently and allow for complex brain processes to occur like reasoning, judgment and communication. Any disruption in myelination results in irreversible damage. Michelle I. Mighdoll et al., *Myelin, myelin-related disorders, and psychosis*, 161(1) Schizophrenia Res., 85–93, 86-87, 90. (2015); Bart D. Peters & Katherine H. Karlsgodt, *White matter development in the early stages of psychosis*. 161(1) Schizophrenia Res., 61–69, 2–4; 6, 10, 12 (Jan. 2015).

[1] White matter, made up of myelin and axons, is the tissue through which messages pass between the different areas of the brain. Anthony A. Mercadante and Prassana Tadi, *Neuroanatomy, Gray Matter*. [Updated 2020 Jul 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; (Jan. 2020). Available from: https://www.ncbi.nlm.nih.gov/books/NBK553239

Established features of structural brain abnormalities as seen in adult onset schizophrenia are similarly seen in childhood onset of schizophrenia. Gogtay and Rapoport, *supra*, at 1123. Augmented loss of brain matter in adolescents with schizophrenia can lead to progressive neurologic impairment. Jay N. Giedd, et al., *Childhood-onset schizophrenia: progressive brain changes during adolescence*, 46(7) Biology Psychiatry, 892–98, 897 (1999).

When compared to typical symptoms of schizophrenia in adults, children show more severe changes in brain functions at the onset of the illness, experience more significant symptoms, are less responsive to treatment, and have poorer outcomes. Francesco Margari et al., *Very early onset and greater vulnerability in schizophrenia: A clinical and neuroimaging study*, 4(4) Neuropsychiatric Disorders Treatment, 825–30, 825 (Aug. 2008).

4. Prevalence of Psychiatric Disorders in Justice-Involved Youth

Psychiatric disorders are highly prevalent in the incarcerated juvenile population. Research has shown that, in detained youth, more than one-half of males and two-thirds of females have at least one notable psychiatric diagnosis (exclusive of conduct disorder). Linda A. Teplin et al., *Psychiatric disorders in youth in juvenile detention*, 59 Arch. Gen. Psychiatry, 1133–43, 1137 (Dec. 2002). *See also* Karen M. Abram et al., *Posttraumatic stress disorder and trauma in youth juvenile*

detention, 61 Arch. Gen. Psychiatry 403–10, 405 (2004) (74% of female youth and 65% of male youth in juvenile detention have a mental illness diagnosis).

Pre-existing mental illnesses are often exacerbated within juvenile justice facilities due to a youth's lack of control inside a facility, limited privacy, strict rules, use of physical disciplinary measures, and separation from family. *See* Simone S. Hicks, *Behind Prison Walls: The Failing Treatment Choice for Mentally Ill Minority Youth*, 39 Hofstra L. Rev. 979, 986–87 (2011) (the juvenile justice system often reacts to youth with mental illness in detention with punishment or isolation, thereby worsening youths' mental health conditions). Increasingly, juvenile facilities have used solitary confinement to manage difficult juvenile inmates because the staff lack proper training as well as sufficient understanding and resources, to handle these juveniles' needs. John Hubner & Jill Wolfson, *Coalition for Juvenile Justice: Serving the Mental Health Needs of Young Offenders*, 56 (Ken Schatz et al. eds., 2000). Detainment also makes it very difficult for family members to be actively engaged throughout the treatment process, leading to a disconnect between any progress made within the facility and the oftentimes discordant reality of their family dynamic. *See* Dept. of Health and Human Services, *TIP 30: Continuity of Offender Treatment for Substance Use Disorders from Institution to Community*, No. (SMA) 98-3245, (1998).

While youth with mental illness of such severity that renders them not responsible for their actions may require treatment within an institutional setting, they would be far more likely to receive the indicated, appropriate services in a therapeutic environment, such as a residential treatment facility, as opposed to a juvenile justice institution. Rani A. Desai et al., *Mental health care in juvenile detention facilities: a review*, 34(2) J. of Am. Acad. of Psychiatry and the L., 204–14, 204, 207, 212 (2006).

C. The Ability to Raise the Insanity Defense is Essential to Fundamental Fairness

The doctrine of fundamental fairness delineates that principles of justice are not born from the Bill of Rights but are those principles and procedures "so rooted in the traditions and conscience of our people as to be ranked fundamental." *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). The differences between the adult criminal and juvenile justice systems cannot serve to inhibit a juvenile's right to fundamental fairness, and essential to fundamental fairness is one's ability to assert the insanity defense. *See In re Gault*, 387 U.S. 1, 16 (1967) (finding the per se rehabilitative nature of the court is not a proper justification to disregard procedural due process).

1. Despite its Rehabilitative Goals, Juvenile Courts Administer Punitive Consequences to Youth

The justice system cannot hide behind the rehabilitative nature of the juvenile court to deny juveniles due process protections that are essential to fundamental

fairness. In fact, in assessing the purported rehabilitative nature of juvenile courts, the *Gault* Court acknowledged that while the concept is benevolent, the ultimate implementation must be examined to determine the true nature of the system. 387 U.S. at 18.

Further, while rehabilitation is one stated goal of Georgia's juvenile justice system, it is not the sole goal. *See* O.C.G.A. § 15-11-1 ("[i]t is the intent of the General Assembly to promote a juvenile justice system that will protect the community, impose accountability for violations of law, provide treatment and rehabilitation, and equip juvenile offenders with the ability to live responsibly and productively."). While perhaps also providing rehabilitation, an adjudication of delinquency in Georgia results in the juvenile's deprivation of liberty, as well as collateral consequences that include stigma, enhanced punishments in the future, as well as loss of educational and economic opportunities.

Placing a child in a detention facility, even if we do not refer to it as a prison or jail, amounts to a deprivation of liberty. *See Gault*, 387 U.S. at 50 ("commitment is a deprivation of liberty. It is incarceration against one's will, whether it is called 'criminal' or 'civil'."). After a youth in Georgia is adjudicated delinquent, juvenile court judges have many disposition options, including placement in Georgia Department of Juvenile Justice ("DJJ") facilities. Depending on the severity of the offense, youth in Georgia may be placed on probation, placed in a secure residential

facility for up to 30 days, committed to DJJ for up to five years, or placed in restrictive custody in a DJJ secure or non-secure residential facility for up to five years. O.C.G.A. § 15-11-601; O.C.G.A. § 15-11-602.

Beyond the physical deprivation of liberty that comes with a delinquency adjudication, the Supreme Court of Georgia has recognized extensive negative collateral consequences stemming from a juvenile's adjudication of delinquency. *In the interest of M.F.*, 305 Ga. 820 (2019). For instance, state and federal law consider a witness with a juvenile record to be less trustworthy than her peers, permitting (under certain circumstances) the impeachment of witness testimony with a delinquency adjudication. *See* O.C.G.A. § 24-6-609(d); Fed. R. Evid. 609(d). Additionally, a court may consider juvenile dispositions when deciding whether to grant bail, or when sentencing a defendant in a criminal trial. *See* O.C.G.A. § 15-11-703 (permitting use of disposition for bail hearings); O.C.G.A. § 17-10-1(e) (permitting use for sentencing); U.S. Sentencing Guidelines Manual § 4A1.2(d)(2) (2016) (counting prior juvenile adjudications as aggravating factors for calculating sentence in federal court).

Beyond these statutory collateral consequences, a delinquency adjudication can serve as a barrier to education and job opportunities. *Gault* recognizes the general stigma associated with juvenile delinquency, 387 U.S. at 24, and the Court of Appeals of Georgia has recognized (in the context of school discipline) that a

child's record may have "adverse consequences . . . particularly as it concerns . . . the ability of a student to obtain employment or enter an institution of higher learning later in life." *Fulton Cnty. Bd. Of Educ. v. D.R.H.*, 325 Ga. App. 53, 60 (2013). Nearly every employer in the country conducts criminal history checks into prospective employees. *See* Nat'l Assoc. of Prof. Background Screeners, *National Survey: Employers Universally Using Background Checks to Protect Employees, Customers and the Public*, 8 (2017). These background checks may reveal juvenile adjudications because, in Georgia, records of juvenile adjudications of class A or class B designated felonies are open to the public, as are records of youth with more than one delinquency adjudication. *See* O.C.G.A. § 15-11-704(b); O.C.G.A. § 15-11- 700(b)(1)-(2). Consequently, employers may reject applicants on the basis of juvenile adjudications thereby limiting their economic opportunities.

Despite its rehabilitative goals, youth in Georgia are not receiving the solicitous care demanded by the Supreme Court due to the disposition options and long-term collateral consequences that result from an adjudication of delinquency. Much like the defendant referenced in *Kent v. United States*, 383 U.S. 541, 556 (1966) Georgia's mentally ill children "receive[ ] the worst of both worlds… get[ting] neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children."

2. The Insanity Defense is a Corollary to the Other Due Process Protections Provided by *Breed*, *Winship*, and *Gault*

The United States Supreme Court has demanded that when a juvenile defendant's liberty is at stake, they must be afforded all protections that are deemed essential to fundamental fairness. *See Breed v. Jones*, 421 U.S. 519 (1975) (the protection against double jeopardy); *In re Winship*, 397 U.S. 358 (1970) (mandating the state prove delinquency beyond a reasonable doubt); *In re Gault*, 387 U.S. 1 (1967) (affording juvenile defendants the right to counsel, the right to written notice of the charges, privileges against self-incrimination, and the right to confront and cross-examine witnesses and accusers at adjudication).

That the insanity defense is essential to fundamental fairness is a natural corollary to *Breed*, *Winship*, and *Gault*. This line of cases is predicated upon the fact that our juvenile justice system, while maintaining components of its rehabilitative ideal, also results in a significant loss of liberty to a child adjudicated delinquent. *Breed*, 421 U.S. at 529; *Winship*, 397 U.S. at 365-66; *Gault*, 387 U.S. at 50. This loss of liberty is why *Gault* requires the provision of a lawyer and the right to confront accusers and cross-examine witnesses; it is why *Winship* requires the highest level of proof before a delinquency finding can be made; and it is why *Breed* found that jeopardy has attached after a juvenile delinquency hearing, prohibiting

retrial in the adult system. *Breed*, 421 U.S. at 541; *Winship*, 397 U.S. at 368; *Gault*, 387 U.S. at 41, 56. [2]

In accordance with the aforementioned cases, a child facing a deprivation of liberty must also be protected from a juvenile delinquency adjudication when that child did not form the requisite *mens rea* to commit an offense that would constitute a criminal act if committed by an adult. This corollary has been recognized by other state courts in their decisions to extend the insanity defense to juveniles in delinquency proceedings. *See People v. Superior Court* (*John D.*), 95 Cal. App. 3d 380, 396 (1979) (insanity defense as applied to juveniles is a means to determine whether a minor can be held culpable for their conduct); *In re Two Minor Children*, 95 Nev. 225, 230 (1979) ("the concept of due process and fairness mandates permitting juveniles to plead . . . the defense of insanity"); *State in Interest of Causey*, 363 So. 2d 472, 474 (La. 1978) ("[t]he function of the insanity plea is much more akin to that of the burden of proof imposed on juvenile proceedings in *Winship*, than of the jury trial involved in *McKeiver*"); *In re Stapelkempr*, 172 Mont. 192, 194–95 (1977) (availability of the insanity defense is necessary to meet the standards of

[2] *McKeiver v. Pennsylvania*, 403 U.S. 528, 530 (1971), which held children are not entitled to jury trials, is inapposite here. While the importance of juries cannot be denied, in McKeiver the Court relied on a judge's ability to serve an equal function in fact-finding. As such, the additional burdens on the juvenile justice system could not be justified. With the insanity defense, not only is a functional equivalent missing, but so is any burden on the system, making this much more akin to *Breed* and *Winshop*.

Kent); *State in Interest of R.G.W.*, 135 N.J. Super. 125, 128 (1975) ("[j]uveniles have every right to a defense of insanity"); *In re Winburn*, 32 Wis. 2d 152, 164 (1966) (insanity defense necessary to conform to the minimum standards of due process and fair treatment required by *Kent*).

While precedent supports the extension of the insanity defense to juvenile defendants, precedent is not the only, nor the most compelling, reason to do so. Fundamental fairness is not born from case law—it is inherent to our society. It is these inherent principles of justice that support the extension of the insanity defense to minors. To hold otherwise would be to deny juveniles the fundamental fairness guaranteed to them not just by the courts, but by the traditions and conscience of a "decent civilized society." *Adamson v. California*, 332 U.S. 46, 61 (1947) (Frankfurter, J., concurring).

The doctrine of fundamental fairness transcends the boundaries of the Constitution. Fundamental fairness is a "fundamental principle of liberty and justice which inheres in the very idea of a free government and is the inalienable right of a citizen of such government." *Twining v. New Jersey*, 211 U.S. 78, 106 (1908). Decades of legal battles have granted legal protection for many of these procedural rights, but it is not the recognition and protection of these rights that creates them. Rather, these rights are inherent to a civilized society, and therefore, courts have recognized the need to protect them.

The ability to avail oneself of the insanity defense is one of these rights inherently connected to the concept of fundamental fairness. The insanity defense is predicated on the justification that a person cannot, fairly, be punished for acts committed while they were in a state of mind lacking the ability to form the requisite *mens rea*. *See* Seth Feuerstine, Frank Fortunati, Charles A. Morgan, Vladimir Corci, Humberto Temporini, and Steven Southwick, *The Insanity Defense*, Psychiatry (Edgmont (Pa. Township)), 2(9), 24–25 (2005). It is fundamentally unfair to hold a person culpable for acts committed in a state of sheer incapacity. Adults are provided the availability of the insanity defense in Georgia for this reason. *Durrence v. State*, 287 Ga. 213, 215 (2010) (finding insanity eliminates the accused's guilt because the accused lacked capacity to distinguish between right and wrong or their will was overpowered by compulsion). As demonstrated above, mental illness does not discriminate based on age.

By recognizing that a juvenile should be availed to the insanity defense, this Court would protect the fundamental fairness and due process afforded to children. Children in the state of Georgia should be provided yet another fair and necessary procedural protection that supports the rehabilitative juvenile justice system function.

IV. CONCLUSION

Mental illness does not only develop in adulthood. Many serious mental illnesses, such as schizophrenia and other disorders with psychotic features, originate in childhood and adolescence. The condition of being a youth does not mitigate the impacts of mental illness; rather, it exacerbates the effects. The Supreme Court stated in *Gault*, "the condition of being a [child] does not justify a kangaroo court." 387 U.S. at 28. Hiding behind the rehabilitative goals of the juvenile court to deny juveniles due process protections is the very harm *Gault* sought to prevent.

As such, *amicus curiae* join Appellant in urging this Court to recognize the applicability of the assertion of the affirmative defense of insanity, including delusional compulsion, in Georgia's state courts.

This submission does not exceed the word count limit imposed by Rule 24.

Respectfully submitted, this 23rd day of November, 2020.

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CERTIFICATE OF SERVICE

I hereby certify that I have this day filed the foregoing AMICUS CURIAE BRIEF OF BARTON CHILD LAW & POLICY CENTER OF EMORY UNIVERSITY SCHOOL OF LAW IN SUPPORT OF T.B., A CHILD, and served all parties by depositing a true and correct copy of same in the United States mail, with adequate postage, and addressed as follows:

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Dated: November 23, 2020

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