

NONCOMPLIANT INSANITY: DOES IT FIT WITHIN INSANITY?

In 1973, Herb Mullin was convicted of murdering thirteen people in Santa Cruz County, California.¹ Before that fateful moment, Mullin had drifted between involuntary commitment, clinical improvement, noncompliance with medications, and release.² His vacillation between treatment compliance and noncompliance is sadly typical.³ Mullin—as far as we can tell—never realized that he was ill and often refused treatment.⁴ One author described Mullin as “refus[ing] to take medication because prophets of God did not need it. Even today he continues to refuse [medication], convinced nothing is wrong with him. He even wonders whether it was the [medication] he took during his initial hospitalization that *caused* his homicidal behavior.”⁵ Indeed, around half of people suffering from schizophre-

1. E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA’S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 24–26 (2008).

2. *See id.* at 26–28.

3. *See, e.g.,* *Brown v. United States*, 682 A.2d 1131, 1133 (D.C. 1996) (“Between 1986 and 1991, Brown returned to the Hospital periodically for inpatient care, both voluntarily and involuntarily . . .”); *Durrence v. State*, 695 S.E.2d 227, 229 (Ga. 2010) (“Evidence showed he had a history of mental illness dating from August 2001 and had been admitted and released from Georgia Regional Hospital on two occasions.”); *State v. Blubaugh*, 491 P.2d 646, 647 (Wash. 1971) (“Defendant Blubaugh had a history of mental illness, having been civilly committed to Western State Hospital in 1965 . . . He was discharged in December, 1966. In March of 1968, . . . defendant went to the wife’s home and, in the presence of two of his children, killed a man who was living with the wife by shooting him six times.”); *id.* (“Defendant Rathbun also had a history of mental illness, and beginning in 1956 had been hospitalized as a paranoid schizophrenic on four separate occasions.”); *State v. Myers*, 222 S.E.2d 300, 303 (W. Va. 1976) (“The court refused to permit the doctor to testify as to information regarding the defendant which had come to him through various medical records regarding the defendant’s military service and resulting psychiatric difficulties.”) *overruled by* *State v. Guthrie*, 461 S.E.2d 163, 185 (W. Va. 1995).

4. TORREY, *supra* note 1, at 67 (“Herb Mullin is sincere in his beliefs about what happened and his own lack of personal responsibility for the crimes. . . . In relating these things, he did so without emotion, as if he were discussing what the prison serves for lunch. He has no more awareness of his illness now than he had thirty-five years ago.”).

5. *Id.* at 116–17.

nia do not realize that they are suffering from an illness and accordingly resist treatment.⁶

The question is what to do about that other half if they commit a crime—that is, those who realize that they have an illness yet still refuse treatment. A classic problem in nearly every introductory criminal law course is what to do with an epileptic defendant who fails to take his medication⁷ or a defendant who consumes a substance that predisposes him to commit a crime.⁸ The case of a schizophrenic defendant is slightly different.⁹ On the one hand, when defendants have insight into their disease and “voluntarily” choose not to take medication, allowing them to plead the insanity defense seems counterintuitive.¹⁰ Indeed, “there is no explicit fault category in the law that we could call something like ‘self-induced insanity’ or ‘voluntary insanity.’”¹¹ On the other hand, that same defendant is suffer-

6. Celso Arango & Xavier Amador, *Lessons Learned About Poor Insight*, 37 SCHIZOPHRENIA BULL. 27, 27 (2011).

7. See, e.g., *Smith v. Commonwealth*, 268 S.W.2d 937, 939 (Ky. 1954) (“Under our view of the case, and in the light of the authorities cited herein, the crucial question is whether Smith failed to do something which a reasonably prudent man would have done under the circumstances.” (citations omitted)); *People v. Decina*, 138 N.E.2d 799, 803–04 (N.Y. 1956) (“[T]his defendant knew he was subject to epileptic attacks and seizures that might strike at any time. . . . How can we say as a matter of law that this did not amount to culpable negligence . . . ?”).

8. See, e.g., *Commonwealth v. Campbell*, 284 A.2d 798, 801 (Pa. 1971) (In a murder committed while under the influence of LSD, “[t]he overwhelming view of our sister Courts and of jurisprudential thought in this Country today supports our decision, i. e., there should be no legal distinction between the voluntary use of drugs and the voluntary use of alcohol in determining criminal responsibility for a homicidal act.” (citations omitted)). See generally Paul H. Robinson, *Causing the Conditions of One’s Own Defense: A Study in the Limits of Theory in Criminal Law Doctrine*, 71 VA. L. REV. 1 (1985).

9. See Michael D. Slodov, Note, *Criminal Responsibility and the Noncompliant Psychiatric Offender: Risking Madness*, 40 CASE W. RES. L. REV. 271, 328 (1989) (“The role of noncompliance with psychiatric treatment as it affects criminal responsibility for a mentally ill criminal offender has been far too long overlooked as an avenue for imposing responsibility.”).

10. See CARL ELLIOTT, *THE RULES OF INSANITY: MORAL RESPONSIBILITY AND THE MENTALLY ILL OFFENDER* 27 (1996) (“The position here seems to be that a person is responsible for getting himself into a state where he does not know what will happen, regardless of what he actually does after that.”).

11. LAWRENCE P. TIFFANY & MARY TIFFANY, *THE LEGAL DEFENSE OF PATHOLOGICAL INTOXICATION: WITH RELATED ISSUES OF TEMPORARY AND SELF-INFLICTED INSANITY* 387 (1990).

ing from a psychosis *at the time of the crime*.¹² In essence, the question is how far back judicial inquiry should extend. Complicating this analysis is a growing body of research that suggests that psychiatric disease can affect many cognitive functions—even those not associated with delusions or psychoses.¹³

This Note seeks to explore the question of insanity caused by an omission, namely failure to take medication. Part I will briefly describe the problem of noncompliance and lack of insight¹⁴ in psychiatric illness, focusing on schizophrenia. Part II will look at the limited judicial interaction with this problem, starting with the recent case of *Commonwealth v. Shin*.¹⁵ Although there are few cases that attempt to grapple with the problem head-on, the rising awareness of mental illness¹⁶ and its potential effects on blameworthiness may soon change that. In any event, the issue lies under the surface in many cases.¹⁷ Part III will consider how far back the inquiry into insanity should extend. This Part will conclude that the mental processes surrounding noncompliance require further elucidation. Part IV, however, will try to solve—or at least re-channel—this empirical question by exploring potential analogies from other areas of criminal law. A conclusion will follow that argues that courts should maintain the status quo for now—and confine the insanity inquiry to the events directly surrounding the

12. See Zachary D. Torrey & Kenneth J. Weiss, *Medication noncompliance and criminal responsibility: Is the insanity defense legitimate?*, 40 J. PSYCHIATRY & L. 219, 221 (2012) (“[B]ut for the defendant’s medication lapse, perhaps there would have been no crime.”).

13. See generally Lei Wang & John G. Csernansky, *Recent Advances in Neuroimaging Biomarkers of Schizophrenia*, in SCHIZOPHRENIA: RECENT ADVANCES IN DIAGNOSIS AND TREATMENT 71 (Philip G. Janicak et al. eds., 2014) (collecting studies).

14. See *infra* notes 23–26 and accompanying text.

15. 16 N.E.3d 1122 (Mass. App. Ct. 2014).

16. Indeed, federal mental health policy has produced a lively debate in recent months. See, e.g., Benedict Carey & Sheri Fink, *Trump’s Pick for Mental Health ‘Czar’ Highlights Rift*, N.Y. TIMES (May 24, 2017), <https://www.nytimes.com/2017/05/24/health/mental-health-czar-elinore-mccance-katz.html> [https://perma.cc/8LYA-QRQB]; D.J. Jaffe, *The Way Forward on Federal Mental Health Policy*, NAT’L REV. (Dec. 18, 2017), <http://www.nationalreview.com/article/454702/federal-agencys-report-problem-serious-mental-illness-good-start> [https://perma.cc/5JFV-KC2K].

17. See *supra* note 3 and accompanying text.

crime. But, as the neuroscience around treatment compliance develops, courts may need to reexamine their approach.¹⁸

I. NONCOMPLIANCE AND LACK OF INSIGHT

The DSM-5¹⁹ defines schizophrenia by the following features:

- A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
 1. Delusions.
 2. Hallucinations.
 3. Disorganized speech (e.g., frequent derailment or incoherence).
 4. Grossly disorganized or catatonic behavior.
 5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
- C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of

18. Cf. David B. Wexler, *Inducing Therapeutic Compliance through the Criminal Law*, in *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 187, 193 (David B. Wexler & Bruce J. Winick eds., 1991) (“The omission problem is somewhat less easy to finesse when we shift our attention from the serotonin situation to, for example, those schizophrenic patients who have a history of violent behavior when they fail to take antipsychotic medication.”).

19. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is used by psychiatric and psychological professionals—as well as courts—as a guide to assessing mental illness. See, e.g., *Hall v. Florida*, 134 S. Ct. 1986, 1990–91, 1994–95, 1998–99 (2014) (citing the DSM throughout the opinion).

the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

- D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).²⁰

Many reviews of this debilitating psychiatric disorder have been published,²¹ but this section will concentrate on lack of insight into the disorder and the possibly related problem of noncompliance with medication. Although the term “insight” refers to several different pathologies in the disease, at its base, lack of insight refers to “reduced awareness of illness and functional impairment and of a need for treatment.”²² Lack of in-

20. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 99 (5th ed. 2013). The definition in DSM-IV-TR is not significantly different—at least with respect to the formal clinical criteria. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 312 (rev. 4th ed., 2000).

21. For a sampling, see generally *Schizophrenia and Other Psychotic Disorders*, in 1 KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1405 (Benjamin J. Sadock et al. eds., 10th ed. 2017) (various monographs by various authors on aspects of schizophrenia); Urs Heilbronner et al., *The Longitudinal Course of Schizophrenia Across the Lifespan: Clinical, Cognitive, and Neurobiological Aspects*, 24 HARV. REV. PSYCHIATRY 118 (2016); Michael J. Owen, Akira Sawa & Preben B. Mortensen, *Schizophrenia*, 388 LANCET 86 (2016).

22. Stephen Lewis, P. Rodrigo Escalona, & Samuel J. Keith, *Phenomenology of Schizophrenia*, in 1 KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 21, at 1406, 1433.

sight is not unique to schizophrenia or even mental illness; many diseases have been associated with lack of awareness into that specific disease process.²³

Insight is not one-dimensional. In fact, even those who understand their disease in an academic way may not fully grasp the significance of their symptoms. For instance, one patient—who happened to be a clinical psychologist himself—explained his symptoms in a relatively detached way:

[C]oncerning my subsequent breakdowns, I notice in retrospect that each time I began to experience an episode, my mind would begin to behave in a particular manner. As I would go into psychosis I would begin to make connections that would lead my thought processes to come to conclusions that in retrospect were very strange. Since those early days I have come to understand that every few months my mind will start over-connecting concepts and ideas. At first this activity can be very interesting, but I have learned that if I allow this process to continue, I will soon be talking and acting in a manner that other persons may view as being problematic.²⁴

Many different types of insight can be defined. For example, one author has proposed dividing the concept into three groups: first, “awareness that one is suffering from a mental illness or condition,” second, “ability to relabel mental events such as hallucinations and delusions as pathological,” and

23. See Daniel C. Mograbi & Robin G. Morris, *Implicit awareness in anosognosia: Clinical observations, experimental evidence, and theoretical implications*, 4 *COGNITIVE NEUROSCIENCE* 181, 181 (2013) (“Unawareness of deficits caused by brain damage or neurodegeneration, termed anosognosia, has been demonstrated in a number of different neurological conditions, including in patients with hemiplegia, hemianopia, aphasia, and memory disorder.”); see also Terry E. Goldberg, Anthony David & James M. Gold, *Neurocognitive impairments in schizophrenia: their character and role in symptom formation*, in *SCHIZOPHRENIA* 142, 156 (Daniel R. Weinberger & Paul J. Harrison eds., 3d ed. 2011) (“Lack of insight is a hallmark of schizophrenia and has been considered to be relevant to cognition. Reasons for this include the analogy with neurological syndromes such as anosognosia, but also the intuition that cognitive processes, such as self-awareness and self-reflection, and judgments about the self are components of insight.”).

24. Frederick J. Frese, *Inside “Insight” – a personal perspective on insight in psychosis*, in *INSIGHT AND PSYCHOSIS: AWARENESS OF ILLNESS IN SCHIZOPHRENIA AND RELATED DISORDERS* 351, 355 (Xavier F. Amador & Anthony S. David eds., 2d ed. 2004).

third “[a]cceptance of the need for treatment.”²⁵ Other commentators have proposed further divisions to comport with clinical observations.²⁶ To be clear, however, a patient experiencing more insight into his condition is not always better; in fact, increased insight is associated with suicidal ideations, distress, and depression.²⁷

Unsurprisingly, the relationship between noncompliance and lack of insight is complex, and the factors overlying the relationship are not yet completely elucidated. Psychiatric medications produce several side effects that can discourage treatment even when a patient acknowledges his mental illness and need for treatment.²⁸ Several studies have nonetheless suggested that patients who have stopped taking their medications believe that they no longer need treatment.²⁹ Although the most severely ill do not acknowledge the schizophrenia diagnosis, many have some inkling of insight that they do have some mental illness—and at least connect taking medication to preventing recommitment.³⁰ These same studies have suggested a link between insight and medication compliance.³¹ Yet patients

25. Anthony S. David, *The clinical importance of insight: An overview*, in INSIGHT AND PSYCHOSIS, *supra* note 24, at 359, 360.

26. *See id.* at 360–61 (collecting examples).

27. Iain Kooyman & Elizabeth Walsh, *Societal outcomes in schizophrenia*, in SCHIZOPHRENIA, *supra* note 13, at 644, 651 (discussing the connection between insight and suicide); *see also* Michael Cooke et al., *Insight, distress and coping styles in schizophrenia*, 94 SCHIZOPHRENIA RES. 12, 20 (2007) (“The findings of this study support the position that possessing good insight, specifically in terms of being aware of having a mental illness and associated problems, is associated with greater distress in schizophrenia.”).

28. *See* John M. Kane & Christoph U. Correll, *Schizophrenia: Pharmacological Treatment*, in 1 KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 21, at 1519, 1525–27; Joseph P. McEvoy, *The relationship between insight into psychosis and compliance with medications*, in INSIGHT AND PSYCHOSIS, *supra* note 24, at 311, 324 (summarizing studies); *see also* Floyd v. State, No. M2000-00318-CCA-R3-CD, 2000 WL 1879513, at *1 (Tenn. Crim. App. Dec. 28, 2000) (“The Appellant’s use of his medication was sporadic. He would often refuse to take the medication for ‘a week or two at a time.’ The Appellant’s refusals to be medicated coincided with his scheduled court appearances. *Additionally, due to the Appellant’s complaints of urinary retention, the medications were often changed.*” (emphasis added)).

29. *See* McEvoy, *The relationship between insight into psychosis and compliance with medications*, in INSIGHT AND PSYCHOSIS, *supra* note 24, at 311, 315–17 (summarizing studies).

30. *See id.* at 316–17 (summarizing studies).

31. *See id.* (summarizing studies).

who once actively³² refused medication were rated to have more severe symptoms even after they were on a stable treatment regimen.³³ Interestingly, these results do not mean that explaining mental illness to a patient increases compliance³⁴—although there are other important reasons to attempt to do so.

With the caveat that insight is a vague clinical term that may represent many pathways arising from many brain regions, neuroimaging studies have begun to shed some light on the phenomenon.³⁵ For instance, one study has found that tissue loss in the insula correlates with loss of insight into the condition.³⁶ More broadly, many studies have begun to link changes in neuroanatomy and brain structure to the cognitive symptoms of schizophrenia, even as it has become increasingly clear that schizophrenia is a global disorder of the brain that arises early in development.³⁷

32. The various studies define “active” refusal differently, but many require some sort of affirmative act besides not inquiring about medication when it does not appear. *See id.* at 317–18.

33. *See id.* (summarizing studies).

34. *See id.* at 326–27 (summarizing studies).

35. Cf. Lisa Feldman Barrett, *The Future of Psychology: Connecting Mind to Brain*, 4 PERSPS. PSYCHOL. SCI. 326, 329 (2009) (“This separation is guided by the neuropsychological assumption that psychological functions are localized to modules in particular brain areas In recent years, however, it has become clear (using multivariate voxel pattern analysis procedures) that the so-called noise carries meaningful psychological information, just as junk DNA is not junk at all. This turn of events makes brain mapping less like cartography (mapping stationary masses of land) and more like meteorology (mapping changing weather patterns or ‘brainstorms’).” (citations omitted)).

36. Lena Palaniyappan, Vijender Balain, & Peter F. Liddle, *The neuroanatomy of psychotic diathesis: A meta-analytic review*, 46 J. PSYCHIATRIC RES. 1249, 1254 (2012) (review of neuroanatomical correlates of clinical expression). *See generally* Laura A. Flashman & Robert M. Roth, *Neural correlates of unawareness of illness in psychosis*, in INSIGHT AND PSYCHOSIS, *supra* note 24, at 157.

37. *See, e.g.*, Sai Ma et al., *Modulations of functional connectivity in the healthy and schizophrenia groups during task and rest*, 62 NEUROIMAGE 1694, 1703 (2012) (“Significant differences between the [Healthy Control] and [Schizophrenia] groups are found, including a more random organization in schizophrenia.”); Paul E. Rasser et al., *Functional MRI BOLD response to Tower of London performance of first-episode schizophrenia patients using cortical pattern matching*, 26 NEUROIMAGE 941, 950 (2005) (“Our data also show a marked reduction of patients’ negative BOLD response in areas subserving sensory auditory information processing when performing a demanding visual planning/working memory task.” (authors discussing tentative results)); Hao-Yang Tan et al., *Dysfunctional Prefrontal Regional Specialization and Compensation in Schizophrenia*, 163 AM. J. PSYCHIATRY 1969, 1976 (2006) (“While high-performing comparison subjects optimally utilized the dorsal

Although much remains to be discovered, at the very least, emerging research into lack of insight in schizophrenia demonstrates that courts ought to treat mental illness quite differently than traditional physical illness. This research calls into doubt the equivalence between “physical” and mental illness that drives the thinking of many courts:

Persons in need of hospitalization for physical ailments are allowed the choice of whether to undergo hospitalization and treatment or not. *The same should be true of persons in need of treatment for mental illness unless the state can prove that the person is unable to make a decision about hospitalization because of the nature of his illness.* It is certainly true that many people, maybe most, could benefit from some sort of treatment at different periods in their lives. *However, it is not difficult to see that the rational choice in many instances would be to forego treatment, particularly if it carries with it the stigma of incarceration in a mental institution, with the difficulties of obtaining release, the curtailments of many rights, the interruption of job and family life, and the difficulties of attempting to obtain a job, drivers license, etc. upon release from the hospital.*³⁸

Nonetheless, courts have been called to deal with cases presenting defendants who argue that they know that medication noncompliance causes them to act inappropriately.

II. JUDICIAL APPROACH TO NONCOMPLIANCE

This section will consider how courts have dealt with defendants pleading insanity but asserting that they know they

prefrontal cortex, schizophrenia patients had greater ventral prefrontal cortex involvement. This compensatory ventral response may reflect loss of hierarchical functional specialization in the diseased prefrontal cortex, which may eventually fail to maintain cognitive performance.”). See generally Danielle S. Bassett et al., *Hierarchical Organization of Human Cortical Networks in Health and Schizophrenia*, 28 J. NEUROSCIENCE 9239 (2008); Emre Bora et al., *Neuroanatomical abnormalities in schizophrenia: A multimodal voxelwise meta-analysis and meta-regression analysis*, 127 SCHIZOPHRENIA RES. 46 (2011); Souhel Najjar & Daniel M. Pearlman, *Neuroinflammation and white matter pathology in schizophrenia: systemic review*, 161 SCHIZOPHRENIA RES. 102 (2015); Claire Scognamiglio & Josselin Houenou, *A meta-analysis of fMRI studies in healthy relatives of patients with schizophrenia*, 48 AUSTL. & N.Z. J. PSYCHIATRY 907 (2014).

38. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1094 (E.D. Wis. 1972) (emphasis added), *vacated on other grounds*, 414 U.S. 473 (1974) (per curiam).

ought to take their medication. Several courts have commented on a history of noncompliance with psychiatric treatment as a prelude to more severe psychotic breaks and, unfortunately, crimes.³⁹ Sometimes, exogenous factors prevent compliance; for instance, some defendants argue that the cost of treatment is prohibitive.⁴⁰ In the case of a patient-defendant who will not take his medication because of the disease, allowing insanity seems fairly clear. Indeed, in the context of a *Strickland*⁴¹ challenge for ineffective assistance of counsel, one court described the near necessity of pleading insanity in such a situation:

It seems to us that the defense of insanity caused by Mr. Hill's failure to continue taking anti-psychotic drugs was an obvious one. . . . The written report of the clinical psychologist who testified for the defense also comments that "[i]t is clear that [Mr. Hill] does much better on antipsychotic medication, but as is typical with paranoid schizophrenics, will

39. See, e.g., *United States v. Session*, No. CRIM. 04-783-01, 2006 WL 2381962, at *9 (E.D. Pa. Aug. 14, 2006) ("Indeed, Session's arrests for assault, kidnaping, and arson occurred during periods of time in which she was medically non-compliant, and Session admitted to becoming violent in the absence of prescription medication, recalling incidents in which she physically struck a nurse, a police officer, and her boyfriend." (citations omitted)); *Laudat v. Gov't of V.I.*, 48 V.I. 892, 897 (D.V.I. App. Div. 2007) (per curiam) ("Laudat's conduct would depend on whether he was actively hallucinating at the time; she noted, however, that Laudat asserted during his evaluation that he was 'not in control because [he was] not taking his medication' at the time of offenses." (citation omitted)); *Galloway v. State*, 938 N.E.2d 699, 707 (Ind. 2010) ("The court also found that the defendant's 'psychotic episodes increased in duration and frequency' and that he 'lacks insight into the need for his prescribed medication.' The court then found that the defendant had 'repeatedly discontinued medication because of side effect complaints and would self medicate' by abusing alcohol and illicit drugs." (citation omitted)); *State v. Junta*, 541 A.2d 284, 286 (N.J. Super. Ct. App. Div. 1988) ("However, the placement in the apartment complex was not the type of structured or supervised environment which had been recommended at the time he left Devereaux."); *State v. Claytor*, 574 N.E.2d 472, 482 (Ohio 1991) ("Appellant had stopped taking his medication and that practice, in the past, had led inexorably to a deterioration of appellant's stability, characterized by episodes of violent conduct leading, in turn, to hospitalization."); *State v. Collazo*, 967 A.2d 1106, 1109 (R.I. 2009) ("Doctor Stewart further detailed defendant's history of noncompliance with his prescribed medication and treatment, and his frequent self-medication with drugs and alcohol, which Dr. Stewart believed exacerbated his mental illness.").

40. See, e.g., *United States v. Burns*, 812 F. Supp. 190, 192 (D. Kan. 1993) ("The defendant testified that at the time of the episode leading to the indictment, he had ceased taking his medications because of the cost.").

41. *Strickland v. Washington*, 466 U.S. 688 (1984).

not take that medication unless forced to. Left in an unstructured situation, it is apparent that medication will be discontinued and the probability of a psychotic episode again becomes very high.”⁴²

Yet, courts have struggled with the situation of a defendant that appears to have some insight into the need for medication and has access to medication—but still refuses to comply. One pervasive problem is that courts tackling this issue have not cited one another. The remainder of this section will attempt to survey approaches to the question and put them in conversation with one another.

The Appeals Court of Massachusetts recently tackled this issue in *Commonwealth v. Shin*.⁴³ The victim boarded a crowded Boston T subway train during rush hour.⁴⁴ At another stop, the defendant boarded the train, “and he went to stand ‘very close’ to the victim, so close that he made her uncomfortable”⁴⁵ The defendant proceeded to touch the victim “between her legs on her upper thigh, within ‘two inches’ of her genital area.”⁴⁶ The victim verbally warned the defendant and pushed him away.⁴⁷ The victim then exited the train before her intended stop to get away from the defendant.⁴⁸ She reported the incident to transit police, who were able to determine the defendant’s identity using his fare card.⁴⁹ Transit officers went to the defendant’s home and verified the fare card information.⁵⁰ While traveling to the police station, “the defendant stated that ‘he did have a problem’ relating to the incident . . . and that he had medication but was not presently taking it.”⁵¹ The subsequent bench trial revealed the defendant’s history of schizophrenia and frotteurism,⁵² similar criminal acts, civil commit-

42. *Hill v. Lockhart*, 28 F.3d 832, 842 (8th Cir. 1994) (alterations in original).

43. 16 N.E.3d 1122 (Mass. App. Ct. 2014).

44. *Id.* at 1123.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.* at 1123–24.

51. *Id.* at 1124.

52. “Frotteuristic disorder, or frotteurism, is a paraphilia in which a person is sexually aroused by the act or fantasy of making unwanted—and often unrecog-

ment, and noncompliance with medications.⁵³ The defense expert opined that the defendant's "ability to perceive reality is significantly impaired. When he willingly takes his medication his symptoms are muted although never in complete remission."⁵⁴

After hearing the evidence, the trial judge requested briefing on the question of "whether the defendant knew that his failure to take his medication would cause him to act in a manner that was against the law and, if so, whether that would permit a finding that he was criminally responsible."⁵⁵ The trial court then rejected the insanity defense and found the defendant criminally liable, concluding that the defendant had enough insight into his condition to know the consequences of not taking his medication:

[T]he defendant "was aware that if he failed to take his medication, it would result in this kind of behavior once again He has had enough contact with the court system and enough treatment by this doctor who testified and other doctors that make it very clear to him that he needs to take his medication or he would be right back where he started."⁵⁶

The Massachusetts Appeals Court reversed and ordered a new trial on grounds that the "judge erroneously took an additional step of inquiring whether the defendant's lack of criminal responsibility was caused by his failure to take prescribed medications."⁵⁷ From the facts provided, it was indeed unclear whether the defendant had taken his medications or even if he could obtain them.⁵⁸ Critically, the court attacked the Commonwealth's reasoning as allowing prosecutors to argue that any mentally ill defendant who had become noncompliant with medication was criminally responsible, negating legiti-

nized—physical contact with others while in public spaces." *Frotteurism*, UNIV. CAL. SANTA BARBARA (Apr. 3, 2014), <http://www.soc.ucsb.edu/sexinfo/article/frotteurism> [<https://perma.cc/9LZU-LKWR>].

53. *Shin*, 16 N.E.3d at 1124–26.

54. *Id.* at 1125.

55. *Id.* at 1126.

56. *Id.* (second alteration in original) (footnote omitted).

57. *Id.* at 1128.

58. *Id.* at 1129.

mate insanity defenses in many cases.⁵⁹ The appeals court thus wished to confine the insanity inquiry to the events surrounding the crime and not extend the timeline back.

In *United States v. Samuels*,⁶⁰ the Eighth Circuit focused on the moments surrounding the crime to assess the sufficiency of an insanity plea and used the defendant's extensive history of commitment and noncompliance to support overturning a jury conviction. The defendant had been accused of mailing a threatening letter to the President.⁶¹ At trial, the defendant produced witnesses who testified to his cycle of treatment, adverse life events, noncompliance, and illness exacerbation:

Typically, after he had been hospitalized and had taken medication long enough to stabilize his behavior and thought processes, he would become happier and hopeful of finding a steady job. However, when he was unable to find work he would begin to withdraw and stop taking his medication. At this point, [the defendant] would become hostile and exhibit paranoid schizophrenic behavior.⁶²

The Court of Appeals concentrated on the defendant's state of mind at the time of the offense and did not find the government's expert testimony, which was based on medical reports from a previous commitment, to counter the defendant's assertion of insanity.⁶³ As such, the Court of Appeals overturned the jury's guilty verdict and remanded for a new trial.⁶⁴

An unreported Ohio criminal case, *State v. McCleary*,⁶⁵ makes explicit the distinction between compliant and noncompliant defendants with which the *Samuels* and *Shin* courts were grappling. The defendant had an eleven-year history of schizophrenia and had been compliant with medication until a few days

59. *See id.* ("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.")

60. 801 F.2d 1052 (8th Cir. 1986).

61. *Id.* at 1053.

62. *Id.* at 1055.

63. *See id.* at 1056. The dissent in that case was willing to credit the jury's use of that testimony. *Id.* at 1057 (Bowman, J., dissenting).

64. *Id.* at 1057.

65. No. CR49471 (C.P. Cuyahoga Cty., Ohio Nov. 19, 1979), *rev'd*, No. CR42116 (Ohio Ct. App. 8th Dist. Nov. 20, 1980). The details of the case are described in Slodov, *supra* note 9, at 303–04.

before he disrobed in a city park and wrestled a handgun from a park ranger.⁶⁶ The trial court refused to find the defendant insane because “there is a distinction between insanity and insanity *that can be controlled*.”⁶⁷ The Ohio Court of Appeals reversed because the identification of a cause of the insanity “did not rebut the existence of [the defendant’s] mental disorder at the time of the offense.”⁶⁸

Analogously, the narrow inquiry into the time of the crime applies not only to the insanity defense but also to the assessment of mens rea in the context of mental illness. In *State v. Davis*,⁶⁹ the jury rejected the insanity defense and convicted the defendant for beating his roommate to death with a rifle barrel.⁷⁰ On appeal, the defendant argued that failure to take medication while mentally ill was negligent or reckless “when he knew or should have known that to do so would allow the symptoms of the disease to emerge.”⁷¹ The appeals court forcefully rejected the defendant’s theory because it tried to expand the timeline of the inquiry too much:

We reject this theory for the reason that the death was not caused by defendant’s failure to take medication. The death was caused by the defendant beating the victim on the head with the barrel of a rifle. It is this conduct which must be judged as reckless or negligent.⁷²

Interestingly, and perhaps in tension with its previous holding, the court implied that the jury might be able to factor the noncompliance into its determination of insanity:

66. *Id.* at 303.

67. *Id.* (emphasis added).

68. *Id.* at 304 (emphasis added).

69. 606 P.2d 671 (Or. Ct. App. 1980). It is important to note that intent and insanity are distinct concepts, though. *See, e.g., State v. Laible*, 1999 SD 58, ¶ 16, 594 N.W.2d 328, 333 (“At trial, several mental health experts explained the typical symptoms of defendant’s diagnosed mental illnesses, the force those illnesses had on his thought processes, the effect of his medication, and the consequence of not taking it. The court properly instructed on the definition of ‘depraved mind.’ Jurors were thus able to compare the expert testimony and the definition to determine the difference between actions evincing a depraved mind and those stemming strictly from defendant’s mental disorders. ‘Sanity and intent are distinct issues.’” (citation omitted)).

70. *Davis*, 606 P.2d at 672.

71. *Id.* at 672–73.

72. *Id.* at 673.

[The defendant's] decision, for whatever reason, to cease taking the prescribed medication may have precipitated a psychosis or a particular state of mind at the time the blows were intentionally inflicted. *From this the jury would be entitled to find he was suffering from a mental disease or defect excluding responsibility for the death*, or that he was suffering from an extreme emotional disturbance and thus guilty of manslaughter. The jury, after proper instruction, rejected both defenses.⁷³

In *State v. Brantley*,⁷⁴ a Louisiana appeals court deferred to the fact finder in determining whether noncompliance should negate an insanity defense. The defendant was charged with multiple counts of passing worthless checks.⁷⁵ At trial, the prosecution produced evidence of a cycle of commitment for manic⁷⁶ symptoms followed by noncompliance with treatment and bouncing checks.⁷⁷ A physician who had treated the de-

73. *Id.* (emphasis added).

74. 514 So. 2d 747 (La. Ct. App. 1987).

75. *Id.* at 748.

76. M. Varga et al., *Insight, symptoms and neurocognition in bipolar I patients*, 91 J. AFFECTIVE DISORDERS 1, 8 (2006) ("Thus, in support of earlier research, acute psychopathology does seem at least partially to have an effect on insight in bipolar disorder. An element of unawareness that is state dependent can be remediated by short-term inpatient treatment, medication adjustment and other interventions. However, our results do not suggest that lack of insight is only state dependent. Mild symptoms were also present during remission." (citation omitted)).

77. See *Brantley*, 514 So.2d at 748-49 ("The state also called as a witness Mrs. McKinney, Brantley's mother, who testified that since 1978 or 1979, he had been in constant trouble with bad checks. She testified, however, that her son had mental problems and was probably not aware that he had written the checks; at least he has always denied it when confronted."); *id.* at 749 ("The physicians advised that though manic depression is not curable, it may be kept in remission by the constant administration of lithium. Carl Gardner, a nurse who has recently treated Brantley, said that if Brantley could maintain a lithium level of .78 to 1.0, his behavior would be normal. The reports from Central State Hospital indicate that Brantley seemed well enough to be discharged within 60 days of admission, but by court order he was held until August 1981, approximately five and a half months."); *id.* ("In 1982, Brantley was again prosecuted for issuing worthless checks. He was jailed in March on two counts. In June, he was rushed to E.A. Conway Hospital in Monroe after an attempted suicide. Dr. Anderson, who treated him, noted complaints of severe headaches and hallucinations. He confirmed the diagnosis of manic depression but felt that it was in remission."); *id.* at 749-50 ("Upon release, Brantley again resumed writing bad checks. In March 1984, he admitted himself to Woodland Hills Hospital in West Monroe, where he was examined by Dr. Sherman, who found him to be in a 'hypomaniac' state, less severe than true mania. After a few days at Woodland Hills, Brantley checked out and

fendant offered an unsympathetic assessment of his culpability, claiming “that if a patient was in a manic state and wrote bad checks, and then admitted himself to a mental hospital, he was ‘quite possibly’ able to recognize that he was sick.”⁷⁸ The trial court convicted the defendant on several counts.⁷⁹ On appeal, after dismissing the defendant’s argument that he had proven insanity to any reasonable jury,⁸⁰ the court noted that a jury could reasonably vote guilty despite his mild mental illness and history of noncompliance:

The evidence would also support the further conclusion that even if Brantley’s conduct was somehow influenced by mild mania or a “hypomaniac” state, then this condition was brought on by his conscious choice not to take the medicine which keeps it under control. . . . If [the defendant] was able to make the conscious choice not to take the medicine, thereby allowing himself to lapse into a manic state which he knew would affect his criminal liability, then he should be accountable for his acts of general criminal intent, committed while in the voluntarily induced manic state.⁸¹

Although *Brantley* involved mental illness less severe than schizophrenia, in *Mitchell v. State*,⁸² a Georgia appeals court—considering a defendant suffering from schizophrenia—suggested that the noncompliance-insanity inquiry should be placed in the hands of the fact finder. After failing to take medication prescribed after an episode of involuntary commitment for schizophrenia, the defendant beat up his mother and threatened his sister.⁸³ At a trial for aggravated assault and making terroristic threats,⁸⁴ the jury, while in deliberation, “requested clarification on whether the failure to take medication . . . relates to the evaluation of that person’s sanity.”⁸⁵ The

immediately admitted himself to Brentwood in Shreveport. There he was examined by Dr. Richie, who had previously seen him in September 1980 and had issued the report that led to his first commitment.”)

78. *Id.* at 750.

79. *Id.* at 748.

80. *Id.* at 751.

81. *Id.*

82. 369 S.E.2d 487 (Ga. Ct. App. 1988).

83. *Id.* at 488–89.

84. *Id.* at 488.

85. *Id.* at 492.

trial court refused to give further instructions, "considering it one of the matters to be deliberated by the jury," and the appeals court affirmed the decision.⁸⁶

As courts have divided on how to treat the question of non-compliance-induced insanity, the question becomes what approach best comports with the purposes of the insanity defense. Doctrinally, insanity concentrates on the defendant's mental state at the time the crime was committed. The next section makes an initial theoretical inquiry into whether the time frame of insanity makes sense or should be expanded.

III. SCOPE OF INQUIRY INTO INSANITY

The insanity defense is caught in a set of conflicting, evolving purposes and policies. In his classic work on the defense, Abraham Goldstein summarized the situation well:

The insanity defense is caught in a cross-current of conflicting philosophies. Its roots are deep in a time when people spoke confidently of individual responsibility and of "blame," of the choice to do wrong. The emphasis was on the individual offender and the defense was seen as an instrument for separating the sick from the bad. It was not long, however, before ideas drawn from social utilitarianism took over the insanity defense. It was now feared that treating an offender as "sick" might weaken the deterrent effect of the criminal law.⁸⁷

These tensions within insanity doctrine lead to ambiguity in the doctrine. This section considers how noncompliance-induced insanity comports with the goals generally served by the insanity defense. This section is not meant to be a comprehensive review of insanity doctrine and theory. Many such reviews and commentaries already exist.⁸⁸ Instead, the discussion

86. *See id.* ("[W]e agree with the trial court that answering the particular inquiry in this case would have stepped over into the province of the jury.").

87. ABRAHAM S. GOLDSTEIN, *THE INSANITY DEFENSE* 211 (1967).

88. *See generally* Peter Arenella, *Convicting the Morally Blameless: Reassessing the Relationship Between Legal and Moral Accountability*, 39 *UCLA L. REV.* 1511 (1992); Stephen J. Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 *S. CAL. L. REV.* 777 (1985); Stephen J. Morse, *From Sikora to Hendricks: Mental Disorder and Criminal Responsibility*, in *THE EVOLUTION OF MENTAL HEALTH LAW* 129 (Lynda E. Frost & Richard J. Bonnie eds., 2001); Michael L. Perlin, *The Insanity Defense: De-*

will focus on issues relevant in establishing how far back to inquire in determining insanity (the criminal action itself as opposed to the contributing noncompliance).

Time frames are critical to criminal law. Actions that appear justified at first glance take on a different tinge when the entire context is considered. Consider the example of a homicide by shooting. Looking only at the moment of the shooting provides limited information. Exploring what happened before is critical: the difference between manslaughter and premeditated, first-degree murder hinges on what the shooter was doing in the moments, days, or weeks before the fateful event.⁸⁹ Although the insanity defense has been expressed in several ways over the last century, the legal formulations seem to concentrate on the time of the crime⁹⁰—unlike other defenses or excuses.⁹¹ In fact, some courts have resisted expanding the time inquiry in insanity beyond the frame necessary for the expert to make the determination:

constructing the Myths and Reconstructing the Jurisprudence, in LAW, MENTAL HEALTH, AND MENTAL DISORDER 341 (Bruce D. Sales & Daniel W. Shuman eds., 1996); Charles E. Trant, *The American Military Insanity Defense: A Moral, Philosophical, and Legal Dilemma*, 99 MIL. L. REV. 1 (1983).

89. Thanks to M. Kyle Reynolds for the helpful example.

90. See, e.g., *Durham v. United States*, 214 F.2d 862, 875 (D.C. Cir. 1954) (“If you the jury believe beyond a reasonable doubt that the accused was not suffering from a diseased or defective mental condition *at the time he committed the criminal act charged*, you may find him guilty.” (emphasis added)), *overruled by* *United States v. Brawner*, 471 F.2d 969, 981 (D.C. Cir. 1972); *Parsons v. State*, 2 So. 854, 866 (Ala. 1887) (“If, by reason of the duress of such mental disease, he had so far lost the *power to choose* between the right and wrong, and to avoid doing the act in question, as that his free *agency was at the time destroyed . . .*” (second emphasis added)); *M’Naghten’s Case* (1843) 8 Eng. Rep. 718, 722 (H.L.) (“[I]t must be clearly proved that, *at the time of the committing of the act*, the party accused was labouring under such a defect of reason . . .” (emphasis added)); MODEL PENAL CODE § 4.01(1) (AM. LAW INST., Proposed Official Draft 1962) (“A person is not responsible for criminal conduct if *at the time of such conduct* as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.” (alterations in original)).

91. See, e.g., MODEL PENAL CODE § 2.09(2) (AM. LAW INST., Proposed Official Draft 1962) (duress) (“The defense provided by this Section is unavailable if the actor recklessly placed himself in a situation in which it was probable that he would be subjected to duress.”); *id.* § 3.04(2)(b)(i) (self-defense) (“[T]he actor, with the purpose of causing death or serious bodily injury, provoked the use of force against himself in the same encounter . . .”).

We think it compatible with the philosophical basis of *M'Naghten* to accept the fact of a schizophrenic episode without inquiry into its etiology. If protection against further harm can reasonably be assured by measures appropriate for the sickness involved, it would comport with *M'Naghten* to deal with the threat in those terms.⁹²

Some courts, in fact, have still found insanity when confronted with evidence that a defendant was cognizant of his atypical mental illness in a lucid phase.⁹³ Although it is unclear whether the various formulations of the defense make any difference at all to jury deliberation,⁹⁴ this Part will attempt to place the theoretical underpinnings of insanity in conversation with time frames in criminal law.

The threshold question to ask is when criminal law can (or should) expand the time frame. Some commentators have argued that the time frame is an arbitrary choice, motivated by policy preferences.⁹⁵ Writing about several criminal law doctrines, including insanity, Professor Kelman argues:

92. *State v. Maik*, 287 A.2d 715, 722 (N.J. 1972) *overruled on other grounds by State v. Krol*, 344 A.2d 289 (N.J. 1975).

93. *See, e.g., Robey v. State*, 456 A.2d 953, 959 (Md. Ct. Spec. App. 1983) (The defense psychiatrist opined that “[a]t the time that this happened she lacked substantial capacity. At the time that this happened, now she knows. Immediately after it happened and it was stopped she knew, yes, that’s the problem.”).

94. Compare Caton F. Roberts & Stephen L. Golding, *The Social Construction of Criminal Responsibility and Insanity*, 15 L. & HUMAN BEHAV. 349, 372 (1991) (“The strongest predictors of verdicts in this study were not the design variables, but rather case construals and attitudes toward the insanity defense.”) with James R. P. Ogloff, *A Comparison of Insanity Defense Standards on Juror Decision Making*, 15 L. & HUMAN BEHAV. 509, 526 (1991) (“The findings presented may have important theoretical implications that provide some support for the contention that, for whatever reason, the particular insanity defense standards employed do not seem to strongly influence a juror’s decision making. Thus, any differences that exist between the ALI and *McNaughten* standard may be practically meaningless.”).

95. MARK KELMAN, *A GUIDE TO CRITICAL LEGAL STUDIES* 93 (1987) (“But while we may understand *why* we use an ordinarily unprivileged *descriptive* discourse here (to preserve a distinct, *normatively* privileged discourse), we must recall that it is our simultaneous access to each discourse that makes the practice available.”); Mark Kelman, *Interpretive Construction in the Substantive Criminal Law*, 33 STAN. L. REV. 591, 592–93 (1981) (“For example, I will show that issues of voluntariness of a defendant’s conduct can be resolved only *after* we have agreed, for reasons outside of our rational discourse, to include within the relevant time frame some obviously voluntary act that contributes to the ultimate harm. . . . [W]e neither frame time the same way in all criminal setting nor do we ever explain why we

These doctrines describe how certain blameworthy acts are in fact blameless because rooted in or determined by factors that preceded the criminal incident. The question, of course, is why the broad⁹⁶ time frame is selected in these cases, while it continues to be excluded as methodologically inappropriate in most other cases *for no apparent reason*.⁹⁷

Others have countered that the choice is not arbitrary at all; criminal law merely looks to determine the time when mens rea and actus rea intersect—that is, when a defendant performs a voluntary act with the requisite intent.⁹⁸ In essence, there is no choice to be made because the inquiry is not about any time frame per se—it is about when the components of a crime come together.⁹⁹ For instance, when an epileptic defendant fails to take his medication and gets behind the wheel, at that moment, the defendant performs an act with the knowledge of inherent risk, so criminal liability attaches.

Regardless of how one resolves the time frame question, the inquiry helps animate the moral analysis of whether a defendant commits a crime *in* ignorance or *of* ignorance.¹⁰⁰ That is, did

use one time frame or another.”) [hereinafter Kelman, *Interpretive Construction in Criminal Law*].

96. Professor Kelman is arguing “broad” in the sense that the defense considers the medical history of the defendant. This distinction is less relevant to this paper. Cf. HERBERT FINGARETTE & ANN FINGARETTE HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 21 (1979) (“In contrast to all this, the insanity defense focuses interest squarely and for its own sake upon the individual character of the defendant’s mind: It is *necessary* to make a judgment that goes well beyond the facts related to this particular offense, a judgment about this particular person, the makeup of *his* mind and personality in its concrete individuality.” (footnote omitted)).

97. Kelman, *Interpretive Construction in Criminal Law*, *supra* note 94, at 611 (emphasis added).

98. See MICHAEL S. MOORE, ACT AND CRIME: THE PHILOSOPHY OF ACTION AND ITS IMPLICATIONS FOR CRIMINAL LAW 36 (2d ed. 2010) (“If there is *any* point in time where the act and *mens rea* requirements are simultaneously satisfied, and from which the requisite causal relations exist to some legally prohibited state of affairs, then the defendant is *prima facie* liable. The presupposition of Kelman’s entire analysis is simply (and obviously) false.”).

99. See *id.* Cf. Robinson, *supra* note 8, at 31 (“Where the actor is not only culpable as to causing the defense conditions, but also has a culpable state of mind *as to causing himself to engage in the conduct constituting the offense*, the state should be punish him for causing the ultimate justified or excused conduct.”).

100. ELLIOTT, *supra* note 10, at 26–27; see also FINGARETTE & HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 43 (“The full and distinctive significance of this condition of irrationality, which makes ascriptions of localized error,

the defendant bring himself to be *in* the ignorant state when he committed the crime—or did he do something *of* which he had no understanding, through no fault of his own? The paradigmatic example is alcohol or drug-induced insanity: Few would argue that a non-alcoholic¹⁰¹ who imbibes too much and commits a crime should be acquitted or have recourse to insanity.¹⁰² That defendant committed a crime *in* ignorance but not *of* ignorance. There was a point in time when the defendant understood his actions and drank anyway. So, even though *at the moment of the crime*, the drunk defendant did not understand or control his acts (and thus was committing his actions *in* ignorance), there was a period of time when the defendant *did* understand—and this is what is punished.

Applying this paradigm to noncompliant insanity, it is unquestioned that at the moment of the crime, the defendant claiming insanity is *in* ignorance of this action. To determine if the defendant is acting *of* ignorance, it is critical to know what he was thinking when he stopped taking the medication (or whenever the defendant's mental processes were "clear"). Was there a conscious choice to become noncompliant—cognizant of the potential consequences? Or, was the noncompliance a flare up or manifestation of the illness—the same disease process that led to criminal actions? One commentator illustrates the potential jumps between noncompliance, belief formation, and criminal action in discussing a particularly tragic home invasion case:

There is, of course, no way to know for certain whether such an illness played any role in the genesis of this incident or in the confused beliefs that this leader espoused to his followers, such as a belief that the police were agents of Satan and that the Bible forbade the drinking of water. Some very tentative indications of his mental state at the time of the incident can be gained from the fact that over the course of the hostage ordeal his conversations with police and supposed

mistake, or ignorance pointless, has been lost from sight because the *words* of idioms have been suggestive of the legal language of 'ignorance.'").

101. The defendant suffering from alcoholism is a different story and will be discussed below in Section IV.A.

102. See ELLIOTT, *supra* note 10, at 27; see also Sections IV.B & IV.C. and accompanying notes.

friends became increasingly confused and disoriented and were finally reduced to sporadic shouts from the house.¹⁰³

Another issue overlaying this causal puzzle is that schizophrenia and other mental disorders make the defendant's testimony potentially unreliable. When the defendant says "I knew something bad was going to happen," the statement may simply not be true or might reflect the insight of a medicated state.

Because the study of insight in schizophrenia and other mental diseases has not yet provided good ways to ferret out this enigma in many defendants, the next section looks at potential analogies for thinking through whether the insanity defense ought to be available in the noncompliance situation. Other criminal law defenses—and the neuroscience underlying them—may provide useful guides to think about noncompliant insanity and provide different methods to probe into the context surrounding a crime.

IV. DOCTRINAL APPROACHES TO NONCOMPLIANCE

This part surveys different doctrines that may shed light on how to treat a noncompliant defendant pleading insanity. Section A will discuss defenses that surround addiction to alcohol and controlled substances, including "settled insanity." Section B will try to provide that fit in cases involving drug ingestion unmasking some sort of mental disease and insanity. Section C will look at self-defense (as a proxy for defenses that bring in the entire situation to analyze the crime). Section D will cover the "multiple personality" defense, whereby defendants attempt to argue that another "person" committed the crime in question. Section E will conclude with three defenses—automatism, amnesia, and duress—that appear to have some relevance to noncompliant insanity defense but do not add much to the inquiry.

103. Richard Sherlock, *Compliance and responsibility: new issues for the insanity defense*, 12 J. PSYCHIATRY & L. 483, 484 (1984).

A. *Defenses Related to Addiction*

It is axiomatic that voluntary alcohol intoxication is not a defense to a crime—and certainly not a complete defense to a crime.¹⁰⁴ Although this categorical position can produce odd results in certain instances,¹⁰⁵ this axiom is not controversial when the defendant is not addicted to the substance in question—that is, when the defendant is truly consuming the substance voluntarily. On the other hand, when the defendant is addicted, the term “voluntary” becomes more fraught. Indeed, crimes that punish mere addiction without an act violate the Eighth Amendment’s prohibition against cruel and unusual punishment,¹⁰⁶ and four members of the Warren Court were ready to declare chronic alcoholism a defense to at least minor offenses.¹⁰⁷ Decades of research has shown that the develop-

104. See *Hopt v. People*, 104 U.S. 631, 633–34 (1881); *Bennett v. State*, 257 S.W. 372, 374 (Ark. 1923) (rejecting a defense of alcohol intoxication for a general intent crime); R.W. Gascoyne, Annotation, *Modern status of the rules as to voluntary intoxication as defense to criminal charge*, 8 A.L.R.3d 1236 (1966) (“The rule that voluntary intoxication is not a general defense to a charge of crime based on acts committed while drunk is so universally accepted as not to require the citation of cases. Apparently no court has ever dissented from the proposition, and it is embodied in statutes in some jurisdictions.” (footnotes omitted)); see also MODEL PENAL CODE § 2.08 (AM. LAW INST., Proposed Official Draft 1962) (Intoxication).

105. Compare *Johnson v. Commonwealth*, 115 S.E. 673, 676–77 (Va. 1923) (defendant who took alcohol to alleviate a toothache cannot use his condition as an excuse), with *Burnett v. Commonwealth*, 284 S.W.2d 654, 658–59 (Ky. 1955) (defendant who took a narcotic for a toothache allowed a jury instruction to take into account his ignorance of the drug’s effects). However, some courts find no problem extending the categorical position to other drugs. See, e.g., *State v. Hall*, 214 N.W.2d 205, 207–08 (Iowa 1974) (collecting cases).

106. See *Robinson v. California*, 370 U.S. 660, 667 (1962) (“We hold that a state law which imprisons a person thus afflicted as a criminal, even though he has never touched any narcotic drug within the State or been guilty of any irregular behavior there, inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment. To be sure, imprisonment for ninety days is not, in the abstract, a punishment which is either cruel or unusual. But the question cannot be considered in the abstract. *Even one day in prison would be a cruel and unusual punishment for the ‘crime’ of having a common cold.*” (emphasis added)).

107. See *Powell v. Texas*, 392 U.S. 514, 569–70 (1968) (Fortas, J., dissenting) (“The findings in this case, read against the background of the medical and sociological data to which I have referred, compel the conclusion that the infliction upon appellant of a criminal penalty for being intoxicated in a public place would be ‘cruel and inhuman punishment’ within the prohibition of the Eighth Amendment. This conclusion follows because appellant is a ‘chronic alcoholic’ who, according to the trier of fact, cannot resist the ‘constant excessive consumption of alcohol’

ment of addiction, whether to alcohol or illicit drugs, leads to tangible changes in brain chemistry and circuitry that turn a pleasurable activity into an obligatory one.¹⁰⁸ The details vary with the substance,¹⁰⁹ but the 10%¹¹⁰ of people exposed to addictive drugs that will develop the most severe forms of addiction go through an “addiction pathway.”¹¹¹ Unfortunately, it is unclear which 10% of people will go through the pathway—though some environmental, epidemiological, and genetic factors have been implicated.¹¹² A recent review of addiction circuits in the brain summarized the transition from experimentation to addiction aptly:

Current evidence shows that most drugs of abuse exert their initial reinforcing effects by activating reward circuits in the brain and that, while initial drug experimentation is largely a voluntary behavior, continued drug use impairs brain function by interfering with the capacity to exert self-control over drug-taking behaviors and rendering the brain more sensitive to stress and negative moods.¹¹³

Of course, like all science, this “brain disease” model is not the only paradigm out there to explain current results, so there

and does not appear in public by his own volition but under a ‘compulsion’ which is part of his condition.”).

108. See Nora D. Volkow & Marisela Morales, *The Brain on Drugs: From Reward to Addiction*, 162 CELL 712, 715 (2015) (“The transition from controlled to compulsive drug taking has been associated with a shift in the involvement of striatal subregions (NAc), implicated in the rewarding response to drugs, to the dorsal striatum that is associated with habit formation.” (citation omitted)).

109. See, e.g., Irina N. Krasnova, Zuzana Justinova, & Jean Lud Cadet, *Methamphetamine addiction: involvement of CREB and neuroinflammatory signaling pathways*, 233 PSYCHOPHARMACOLOGY 1945, 1958 (2016) (“Cytokines and chemokines released by activated microglia appear to also play important roles in METH-induced neuronal injury and neuropsychiatric impairments, which include cognitive deficits, depression, and anxiety.” (citation omitted)).

110. See Nora D. Volkow, George F. Koob, & A. Thomas McLellan, *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENGL. J. MED. 363, 367–68 (2016).

111. See *id.* at 365 fig.1.

112. See Louisa Degenhardt & Wayne Hall, *Extent of illicit drug use and dependence, and their contribution to the global burden of disease*, 379 LANCET 55, 58–60 (2012) (detailing risk factors and the natural history of the disease).

113. Volkow & Morales, *The Brain on Drugs: From Reward to Addiction*, 162 CELL at 712.

is dissent from this view.¹¹⁴ Nonetheless, the results of these studies do at least suggest that there is something “involuntary” about substance use once addiction sets.

Some courts have ignored this evidence. To be fair, some of this hostility has been driven by legislatures singling out alcohol for special treatment.¹¹⁵ One court, however, was particularly clear in highlighting other courts’ rejection of the science circa 1969:

The courts in considering the questions here discussed have taken little or no notice of modern medical attitudes toward alcoholism as a disease, but have usually assumed that the intoxication must be treated as voluntary for purposes of determining criminal guilt, no matter how compulsive the accused’s addiction to alcohol may have been.¹¹⁶

In contrast, some courts are willing to acknowledge that the disease of addiction can lead to dysfunctional behavior suffi-

114. See generally Wayne Hall, Adrian Carter, & Cynthia Forlini, *The brain disease model of addiction: is it supported by the evidence and has it delivered on its promises*, 2 LANCET PSYCHIATRY 105 (2015). For the rebuttal, see Nora D. Volkow & George Koob, *Brain disease model of addiction: why is it so controversial?*, 2 LANCET PSYCHIATRY 677 (2015).

115. See, e.g., *Jones v. State*, 648 P.2d 1251, 1255 (Okla. Crim. App. 1982) (“Therefore, in the area of voluntary intoxication we find that our statutes are controlling. The Oklahoma legislature has determined that voluntary intoxication should not completely relieve one of criminal responsibility. Any change in this public policy statement must come from that branch of government and not from the judiciary.”). But see *Commonwealth v. Wallace*, 439 N.E.2d 848, 850 (Mass. App. Ct. 1982) (“Although the circumstances of a person who drives after taking a prescription drug unaware of its possible effects differ significantly from those of a person forced to drive after having a potion rammed down his throat or after being tricked, such circumstances also differ substantially from those of a person who drives after voluntarily consuming alcohol or drugs whose effects are or should be known. The law recognizes the differences, and authorities have characterized as ‘involuntary intoxication by medicine’ the condition of a defendant who has taken prescribed drugs with severe unanticipated effects.” (footnote omitted)).

116. *Utsler v. State*, 171 N.W.2d 739, 741 (S.D. 1969) (quoting Gascoyne, *supra* note 104); see also *United States v. Lyons*, 731 F.2d 243, 252 (5th Cir. 1984) (en banc) (Rubin & Williams, JJ., concurring and dissenting) (“The contention he presents is that iatrogenic addiction stands on a different footing from voluntary addiction. Our opinion in *Bass* did not rely on the involuntariness of the defendant’s addiction. Because the extent of the mental incapacity represented by narcotics addiction is exactly the same whether voluntarily or involuntarily induced, we see no reason to create a distinction on that basis.”).

cient to trigger some defenses.¹¹⁷ And other courts countenance the sequelae of alcoholism—for instance, an alcohol-induced seizure¹¹⁸—as a defense. In a dramatic example of the latter, in *State v. Massey*,¹¹⁹ the Supreme Court of Kansas allowed the defendant to plead unconsciousness or automatism based on a seizure triggered by consuming alcohol.¹²⁰

Taking this line of reasoning further, some jurisdictions will consider alcoholism as a defense when it “produces a permanent and settled insanity distinct from the alcoholic compulsion itself that the law will accept it as an excuse.”¹²¹ So-called “settled insanity” is a condition of mental illness that arises from chronic abuse of many substances that cause an acute intoxication. This defense is in tension with the common law position that voluntary intoxication is no defense,¹²² for the line between voluntary intoxication and that voluntary intoxication becom-

117. See, e.g., *Green v. United States*, 383 F.2d 199, 201 (D.C. Cir. 1967) (Burger, J.); see also *Brinkley v. United States*, 498 F.2d 505, 511 (8th Cir. 1974).

118. See generally Matti Hillbom et al., *Seizures in alcohol-dependent patients: epidemiology, pathophysiology and management*, 17 CNS DRUGS 1013 (2003). The precise causation—that is, whether the alcohol itself or the withdrawal thereof induces the seizure—is unclear.

119. 747 P.2d 802 (Kan. 1987).

120. *Id.* at 808.

121. *Utsler*, 171 N.W.2d at 741 (quoting Gascoyne, *supra* note 104); see also *Perkins v. United States*, 228 F. 408, 416–17 (4th Cir. 1915) (“The distinction, thus broadly stated, between insanity produced by disease coming as an act of God and that produced by a man’s own voluntary act is not sound, for real mental disease amounting to insanity, as distinguished from ordinary intoxication, excuses, even when brought about by voluntary dissipation or other vice.”); *Parker v. State*, 254 A.2d 381, 388–89 (Md. Ct. Spec. App. 1969) (collecting cases). But see, e.g., *Bieber v. People*, 856 P.2d 811, 818 (Colo. 1993) (“Thus we determine that the ‘settled insanity’ doctrine conflicts with our present statutory scheme regarding insanity and self-induced intoxication. Naturally, the General Assembly, should it disagree with our interpretation, is free to adopt the ‘settled insanity’ doctrine through new legislation. Without such action, however, we cannot recognize ‘settled insanity’ as a valid defense.”).

122. See, e.g., *Bieber*, 856 P.2d at 816 (“We do not see any qualitative difference between a person who drinks or takes drugs knowing that he or she will be momentarily ‘mentally defective’ as an immediate result, and one who drinks or takes drugs knowing that he or she may be ‘mentally defective’ as an eventual, long-term result. In both cases, the person is aware of the possible consequences of his or her actions. We do not believe that in the latter case, such knowledge should be excused simply because the resulting affliction is more severe.”).

ing something else is quite blurry.¹²³ Indeed, “settled insanity” can be caused by repeated bouts of voluntary intoxication.¹²⁴ But, despite the doctrine’s logical flaws and consistency issues, courts have been willing to recognize it even when that line is not clear at all—and leave the issue to the jury. One early example, in the context of alcohol abuse, follows:

Although delirium tremens is the product of intemperance, and therefore in some sense is voluntarily brought on, yet it is distinguishable, and by the law is distinguished, from that madness which sometimes accompanies drunkenness. If a person suffering under delirium tremens is so far insane as I have described to be necessary to render him irresponsible, the law does not punish him for any crime he may commit. But if a person commits a crime under the immediate influence of liquor, and while intoxicated, the law does punish him, however mad he may have been. It is no excuse, but rather an aggravation of his offence, that he first deprived himself of his reason before he did the act.¹²⁵

Some courts have extended the defense to chronic consumption of substances triggering a sustained altered mental state. In *People v. Kelly*,¹²⁶ the California Supreme Court found that a defendant accused of attempted murder and related crimes after having stabbed her mother multiple times could plead insanity based on “using [mescaline and LSD] 50 to 100 times in

123. Cf. *TIFFANY & TIFFANY*, *supra* note 11, at 11 (“First, pathological intoxication should not be treated as voluntary intoxication in all cases because that tends to beg the question regarding voluntariness and because it is not intoxication in the usual sense in any event. We will discuss some cases in which the court essentially identifies drinking alcohol as the fault on the part of the actor. Thus, pathological intoxication, being triggered by consumption of alcohol, would never be a defense, and that seems wrong to us.”).

124. See, e.g., *State v. Kavanaugh*, 53 A. 335, 336 (Del. Ct. Gen. Sess. 1902) (“And just there we will say to you, in regard to persons afflicted with habitual or fixed insanity from long-continued habits of intoxication, that, although their madness caused thereby was at first contracted voluntarily, the person so affected will nevertheless be deemed irresponsible for criminal acts committed by him.”).

125. *United States v. McGlue*, 26 F. Cas. 1093, 1097 (C.C.D. Mass. 1851) (No. 15,679) (Curtis, Circuit Justice); see also *Choice v. Georgia*, 31 Ga. 424, 455 (1860) (“To illustrate this idea: If, by a long practice of intoxication, an *habitual* or *fixed* insanity is caused, or a permanent injury to the mind produced—although this madness was at first contracted voluntarily, yet the party is in the same situation in regard to responsibility for crime, as in a state of insanity caused by nature or accident.”).

126. 516 P.2d 875 (Cal. 1973).

the months leading up to the offense.”¹²⁷ The court stressed that “if defendant was insane at the time of the offense, it is immaterial that her insanity resulted from repeated voluntary intoxication, as long as her insanity was of a settled nature.”¹²⁸ The facts need not be so extreme. A particularly dramatic trip on LSD after several administrations over two weeks that resulted in the defendant stabbing his younger brother was sufficient to allow one court to remand for a trial to determine whether the insanity was settled.¹²⁹

In the context of noncompliant insanity, settled insanity helps answer the question of how to treat a defendant’s discontinuation of medication. On the background of mental illness that is difficult to treat in some cases,¹³⁰ settled insanity teaches that it is irrelevant whether the initial decision to stop medication was “voluntary,” “involuntary,” or something in-between. Indeed, considering that schizophrenia is not self-induced or does not have a “voluntary phase,” if courts are willing to brook “settled insanity,” they should be able to permit non-compliant insanity. Of course, one could counter that schizo-

127. *Id.* at 876–77, 882–83.

128. *Id.* at 883; *see also* Porreca v. State, 433 A.2d 1204, 1208 (Md. Ct. Spec. App. 1981) (“A distillation of the legal principles involved shows that, although we do not want a criminal to escape punishment by the simple expedient of getting drunk first, neither do we want to punish anyone who is legally insane, even though the cause of his insanity is a long-term use of drugs or alcohol.” (footnote omitted)); Commonwealth v. Herd, 604 N.E.2d 1294, 1299 (Mass. 1992) (“The weight of authority in this country recognizes an insanity defense that is based on a mental disease or defect produced by long-term substance abuse. We see no logical reason for rejecting a drug-induced mental disease or defect as a basis for the application of the *McHoul* test simply because the disease or defect is caused only by the drug ingestion. We are unwilling, in order to justify a homicide conviction, to permit the moral fault inherent in the unlawful consumption of drugs to substitute for the moral fault that is absent in one who lacks criminal responsibility.” (footnote omitted)).

129. *See* People v. Conrad, 385 N.W.2d 277, 277–78, 280–81 (Mich. Ct. App. 1986).

130. *See* Sarah D. Holder & Amelia Wayhs, *Schizophrenia*, 90 AM. FAMILY PHYSICIAN 775, 781 (2014) (“In the past, schizophrenia was viewed as a disease with a poor prognosis. Currently, the disease course and response to treatment are marked by heterogeneity; differences in treatment response, disease course, and prognosis are to be expected. Despite adequate treatment, one-third of patients will remain symptomatic. Although most patients need some form of support, most are able to live independently and actively participate in their lives.” (footnotes omitted)).

phrenia is often treatable,¹³¹ whereas settled insanity is sometimes not—at least in the short-term.¹³² Yet settled insanity is triggered by one's actions, whereas most are blameless for developing schizophrenia.¹³³ This would suggest that the insanity defense should be available *regardless of whether the noncompliance was voluntary in any sense that law finds cognizable*.

But the analogy breaks down on two grounds. First, the settled insanity cases require multiple triggers (for example, many instances of drug intake) whereas going off medication takes missing a single dose. Of course, missing a single dose does not

131. *But see* John Lally et al., *Treatment-resistant schizophrenia: current insights on the pharmacogenomics of antipsychotics*, 9 PHARMACOGENOMICS & PERSONALIZED MED. 117, 118 (2016) (“There are currently no evidence-based pharmacotherapies for the 30% of [treatment-resistant schizophrenia] patients who fail to respond to clozapine or those who discontinue clozapine due adverse events.” (footnotes omitted)).

132. *See, e.g.*, Henry D. Abraham & Andrew M. Aldridge, *Adverse consequences of lysergic acid diethylamide*, 88 ADDICTION 1327, 1329–31 (1993) (collecting studies describing “prolonged” psychosis after LSD use). Indeed, studies have linked marijuana with unmasking psychosis or schizophrenia earlier. *See, e.g.*, Cécile Henquet et al., *Prospective cohort study of cannabis use, predisposition for psychosis, and psychotic symptoms in young people*, 330 BR. MED. J. at 3 (2004) (online journal) (“Exposure to cannabis during adolescence and young adulthood increases the risk of psychotic symptoms later in life. The findings confirm earlier suggestions that this association is stronger for individuals with predisposition for psychosis and stronger for the more severe psychotic outcomes. Frequent use of cannabis was associated with higher levels of risk in a dose-response fashion. Associations were independent of other variables known to increase the risk for psychosis. Also, the effect of cannabis remained significant after we corrected for baseline use of other drugs, tobacco, and alcohol. Finally, the data did not support the self-medication hypothesis as baseline predisposition for psychosis did not significantly predict cannabis use at follow up.” (footnotes omitted)); Mohini Ranganathan, Patrick D. Skosnik, & Deepak Cyril D’Souza, *Marijuana and Madness: Associations Between Cannabinoids and Psychosis*, 79 BIOLOGICAL PSYCHIATRY 511, 512 (2016) (commentary) (“In conclusion, exposure to cannabinoids is associated with a range of psychosis outcomes.”). *But see, e.g.*, Ian Hamilton, *The need for health warnings about cannabis and psychosis*, 3 LANCET PSYCHIATRY 322, 322 (2016) (“We need to be cautious when calling for health warnings as Mathew Large does on the issue of cannabis and psychosis.”).

133. However, drug abuse can lead to earlier presentation of schizophrenia and other mental disorders. *See, e.g.*, Marc De Hert et al., *Effects of cannabis use on age at onset in schizophrenia and bipolar disorder*, 126 SCHIZOPHRENIA RES. 270, 274 (2011) (“The current results show that cannabis use is associated not only with a lower age at onset in schizophrenia patients but also in other disorders in which psychotic symptoms are highly prevalent such as bipolar disorder. This could indicate that cannabis use may unmask a pre-existing genetic liability that is partly shared between patients with schizophrenia and bipolar disorder, as suggested by recent evidence showing considerable genetic overlap.” (citation omitted)).

make a noncompliant patient, but missing one dose makes the patient more likely to miss the next.¹³⁴ The second issue is the act versus omission distinction. Settled insanity is produced by “taking” something; noncompliant insanity is caused by “not taking.” Perhaps the formal distinction should not matter, but the law does continue to treat acts and omissions differently¹³⁵—especially if there is no legal duty to take medication. Now, one may argue that because omissions do not lead to criminal liability when there is no duty to act, so too noncompliance-driven insanity should be excused. But many treated mentally-ill individuals have at least an inkling that their medication prevents them slipping back into an ill state.¹³⁶ The first time the defendant “decides” (though it is unclear if they voluntarily decide) to stop taking medication, a chain of events potentially leading to crime begins. Thus, the defendant could be just as responsible for this decision as he would be for any affirmative act. Considering cases of substance ingestion triggering mental illness helps provide some insight into these problems: one trigger (whether an act or an omission), one episode of insanity, one crime. The next section turns to that question.

B. *Unmasking Mental Illness and Insanity*

“Settled insanity” leaves open the question of whether a defendant can be exculpated if he consumes a substance that “unmasks” a latent mental illness, has an unexpected reaction, or is tricked into consuming a psychoactive drug. Assuming the court does not automatically equate psychoactive drugs with the particularly harsh treatment of alcohol,¹³⁷ it could conclude that a defendant has voluntarily consumed a substance but has not intended it to have a particular effect.

134. Cf. Michael Birnbaum & Zafar Sharif, *Medication adherence in schizophrenia: patient perspectives and the clinical utility of paliperidone ER*, 2 *PATIENT PREFERENCE & ADHERENCE* 233, 234 (2008) (“However, it has been demonstrated that even minor deviations from prescribed regimens can be associated with deleterious outcomes.”).

135. See generally Luis E. Chiesa, *Actmissions*, 116 *W. VA. L. REV.* 583 (2013).

136. See *supra* Part I.

137. See, e.g., *State v. Hall*, 214 N.W.2d 205, 211 (Iowa 1974) (LeGrand, J., dissenting) (“I cannot agree that drug intoxication should be treated the same as that resulting from the use of alcohol.”).

Although there is some disagreement on how to treat such a case,¹³⁸ some courts have been willing to allow insanity or some reduction of mens rea—if the defendant does not know that the substance unmasks the illness. Essentially, it is a “fool me once, shame on you; fool me twice, shame on me” type of situation. As the Massachusetts Supreme Judicial Court has explained, the defense “is not available to a defendant with a mental disease or defect who knows that his consumption of a substance will cause him to be substantially incapable of either appreciat-

138. Compare *People v. Penman*, 110 N.E. 894, 900 (Ill. 1915) (“The plaintiff in error attempted to prove that the man who gave him the tablets in Danville told him they were breath perfumers, but was not permitted to do so. The testimony should have been received. The defense of insanity was based upon the taking of those tablets, and whether the defendant took them voluntarily, knowing what they were, or involuntarily took cocaine, supposing it to be some innocent thing, was a question materially affecting his responsibility. It was proper to show what was said, in order to show that he was deceived into taking the tablets, supposing them to be innocent.”), and *People v. Kelley*, 176 N.W.2d 435, 441 (Mich. Ct. App. 1970) (“It was, therefore, incorrect to charge that intoxication would not be a defense if Kelley knew before he began to drink that if he became drunk he might commit ‘a crime’—any crime.”), with *Kane v. United States*, 399 F.2d 730, 736 (9th Cir. 1968) (“It is true that, because of pathological intoxication, it took less liquor to produce unsocial results than with one not so afflicted, and the unsocial results were more serious than in the case of normal intoxication. But still, the disability which he does acquire from drinking liquor was within his own control and cannot be classified as a mental illness excusing criminal responsibility.”), and *United States v. Hernandez*, 43 C.M.R. 59, 63 (C.M.A. 1970) (“Many persons with a low tolerance for alcohol have been held responsible for military offenses they committed while under alcoholic influence and without realizing their threshold of intoxication.”), and *Roberts v. People*, 19 Mich. 401, 422–23 (1870) (“But if he was ignorant that he had any such tendency to insanity, and had no reason from his past experience, or from information derived from others, to believe that such extraordinary effects were likely to result from the intoxication; then he ought not to be held responsible for such extraordinary effects; and so far as the jury should believe that his actions resulted from these, and not from the natural effects of drunkenness, or from previously formed intentions; the same degree of competency should be required to render him capable of entertaining, or responsible for the intent, as when the question is one of insanity alone, which I now proceed to consider.”), and *State v. Sette*, 611 A.2d 1129, 1138 (N.J. Super. Ct. App. Div. 1992) (“We conclude that the judge’s instructions were sound and that, where a defendant, as here, voluntarily ingests large amounts of illegal intoxicants and intentionally overdoses on legal drugs, he cannot assert that he unexpectedly reacted violently to those drugs due to an unknown, underlying pathological condition which afflicted him.”).

ing the wrongfulness of his conduct or conforming his conduct to the requirements of law (or both)."¹³⁹

In one particularly dramatic case, *People v. Low*,¹⁴⁰ the Colorado Supreme Court considered the case of a defendant who had been driven to "insanity" by overconsumption of cough drops.¹⁴¹ The defendant suffered from a cold approximately six months prior to the crime when he began to take a brand of cough drops that contained dextromethorphan.¹⁴² Following his illness, the defendant began abusing cough drops "as a partial substitute for chewing tobacco and in an effort to quit smoking."¹⁴³ During the twenty-four hours leading up to his crime, he did not sleep, and he consumed over 120 cough drops (approximately one gram of dextromethorphan).¹⁴⁴ His behavior accordingly became bizarre:

On the trip up the mountain road, the defendant became increasingly anxious and apprehensive, and had feelings of unreality. He began to notice that the trees surrounding the road had a particular type of bark that was "soft and unnatural." He was paranoid and questioned his stepson about what was occurring and why he was being "tricked." At approximately the halfway point to the camp, the defendant

139. *Commonwealth v. Ruddock*, 701 N.E.2d 300, 302 (Mass. 1998); see also *United States v. Santiago-Vargas*, 5 M.J. 41, 42-43 (C.M.A. 1978) ("[T]he appellant does not come within its scope because he knew that, when intoxicated, he behaved in a violent manner."); *Mullin v. State*, 425 So.2d 219, 220 (Fla. Dist. Ct. App. 1983) ("Additionally, we note no support for the lower court's exclusion of testimony regarding appellant's condition. Appellant's expert witness, a neurologist, was qualified to testify to the medical effects of sniffing glue and other hydrocarbons upon human behavior if he knew the effects. Appellant's testimony of his prior abuse, if relevant to the above medical opinion, would also be admissible to establish a voluntary intoxication defense to the specific intent crime."); *Commonwealth v. Brennan*, 504 N.E.2d 612, 616 (Mass. 1987) ("The court in [a previous Massachusetts case] suggested that if the jury finds that the defendant had a latent mental disease or defect which caused the defendant to lose the capacity to understand the wrongfulness of his conduct or to conform his conduct to the requirements of the law, lack of criminal responsibility is established even if voluntary consumption of alcohol activated the illness, unless he knew or had reason to know that the alcohol would activate the illness. We adopt that suggestion here." (citation omitted)).

140. 732 P.2d 622 (Colo. 1987).

141. *Id.* at 625-26.

142. *Id.* at 625

143. *Id.*

144. *Id.*

stopped his pickup truck. When Kim and Roller stopped their truck to make sure everything was all right, [the defendant] demanded that all of the individuals kneel in prayer with him. Kim testified that he had never known Low to be “a religious person,” but imagined that the beauty of the wilderness inspired Low to demand the prayer session. Upon concluding the prayer, Low insisted that Roller drive Shane to the campsite in Kim’s truck, and that Kim drive Low’s truck with Low as a passenger. Kim complied because Low appeared to be tired from his trip from Missouri. During the remainder of the ride to the campsite, the defendant speculated on whether he was alive or dead.¹⁴⁵

He then stabbed a member of his hunting party and attempted to stab himself.¹⁴⁶ At trial, the defense expert asserted that the dextromethorphan caused an “organic delusional syndrome” or “toxic psychosis.”¹⁴⁷ The trial court found that the prosecution failed to prove *mens rea*.¹⁴⁸ The appellate court considered whether the facts would fit a defense of involuntary intoxication.¹⁴⁹ The court defined the defense as “intoxication that is not self-induced, and by definition occurs when the defendant does not knowingly ingest an intoxicating substance, or ingests a substance not known to be an intoxicant.”¹⁵⁰

145. *Id.* at 624.

146. *See id.* at 625.

147. *Id.*; see also Barry K. Logan et al., *Dextromethorphan Abuse Leading to Assault, Suicide, or Homicide*, 57 J. FORENSIC SCI. 1388, 1388 (2012) (“There is a significant Internet drug subculture regarding the recreational use of dextromethorphan, discussing and promoting the intoxicating and hallucinogenic effects of the drug, including out-of-body experiences which can be achieved by increasing dose levels through four ‘plateaus’ to achieve the ultimate dissociative high.” (citation omitted)).

148. *Low*, 732 P.2d at 626.

149. *See id.* at 627. The court also opined on insanity and impaired mental condition. *See id.* at 627–30.

150. *Id.* at 627 (emphasis added) (citing COLO. REV. STAT. ANN. § 18-1-804 (West 2017)); see also *City of Minneapolis v. Altimus*, 238 N.W.2d 851, 858 (Minn. 1976) (“Involuntary intoxication, we note in summary, is a most unusual condition. The circumstances in which an instruction on the defense of involuntary intoxication will be appropriate will accordingly be very rare. We hold, nevertheless, that in the instant case such an instruction was necessary because defendant introduced evidence sufficient to raise the defense of temporary insanity due to involuntary intoxication. Defendant’s evidence indicated that at the time he committed the acts in question he was intoxicated and unaware of what he was doing due to an unusual and unexpected reaction to drugs prescribed by a physician. We further believe that failure to give an instruction on involuntary intoxication was prejudicial error in view of the finding of not guilty on the charge of simple assault, a

To be clear, the defense is not a license to excuse errors in drug ingestion. Accordingly, it requires more than the defendant's mere subjective belief about the nature and effects of the substance. Several jurisdictions have predicated the availability of the defense on whether a reasonable person could expect that a given drug (or its typical pairings) could produce the given effect. In *People v. Velez*,¹⁵¹ a California appellate court refused to permit an involuntary intoxication jury instruction to a defendant who had smoked a marijuana cigarette laced with PCP because a reasonable person should be aware that the drugs are often mixed.¹⁵² In contrast, courts have been more sympathetic to defendants that suffer from unexpected effects of prescription drugs,¹⁵³ though the success of the defense depends on the context of the prescription use.¹⁵⁴

finding which suggests very strongly that the jury believed defendant's evidence that the Valium was responsible for his behavior.").

151. 221 Cal. Rptr. 631 (Cal. Ct. App. 1985).

152. *See id.* at 637–38. The illegality of both drugs also influenced the court's thinking. *See id.* at 636 ("A plausible argument could be made that, as a matter of policy, defendant should not be wholly excused from criminal responsibility for harm caused others, and arising out of his consumption of an unlawful drug, on the ground that allowance of such an excuse would sanction consumption of unlawful drugs."). Similarly, a Pennsylvania appellate court refused to excuse an interaction between a benzodiazepine and alcohol. *See Commonwealth v. Todaro*, 446 A.2d 1305, 1308 (Pa. Super. Ct. 1982).

153. *See Perkins v. United States*, 228 F. 408, 415 (4th Cir. 1915) ("A patient is not presumed to know that a physician's prescription may produce a dangerous frenzy. But he is bound to take notice of the warning appearing on a prescription, and this obligation is, of course, stronger if he reads the prescription. If, for example, in this case, the prescription itself, or the realized effect of the first dose of the chloral, or both together, warned the defendant before he had lost control of himself that he might be thrown into an uncontrollable frenzy [sic], then he would be guilty of murder or manslaughter according to the view the jury might take of the circumstances."); *Crutchfield v. State*, 627 P.2d 196, 200 (Alaska 1980) ("The drug tranxene was given to Crutchfield by his physician. He had no notice that it was a drug whose use while driving was prohibited under [Alaska Law]. Moreover, he had no way of discovering the prohibited character of the drug until expert testimony at trial indicated that it had a composition similar to valium, a drug specifically prohibited by regulation. Under these circumstances, it appears that Crutchfield could not reasonably understand that his contemplated conduct was prohibited." (footnote omitted)); *Burnett v. Commonwealth*, 284 S.W.2d 654, 659 (Ky. 1955) ("If the jury shall believe from the evidence that when the defendant's automobile struck Mrs. Oakley Wells (if you shall believe from the evidence beyond a reasonable doubt that it did so), the defendant was under the influence of drugs taken under a physician's prescription to such an extent that he was incapacitated from exercising slight care in operating his automobile, and that he did

In considering the case of noncompliant insanity, the unmasked mental illness defense presents a simple question: did the defendant know what was going to happen when he stopped the medication? It is unclear how closely the defendant's accused criminal acts must be to previous off-medication behavior.¹⁵⁵ Nonetheless, this question goes to the issue of whether the defendant—while treated—believed that he suffered from some mental illness. Theoretically, looking at the defendant's medical records should easily determine this question. That is, while on treatment, did the patient demonstrate an understanding that he was ill and of the consequences of stopping treatment? Yet what a defendant said to his provider is relevant but not dispositive—even if the defendant had a regular physician or therapist. What is more relevant, and perhaps dispositive but very difficult to determine, is what the defendant was thinking when he stopped taking medication. Did his mental illness “flare” up and drive him towards noncompliance? Circumstantial evidence may provide some insight into that question, but in the end, the question is one of mental state that criminal law is left to infer.¹⁵⁶

The next section considers a criminal defense doctrine that looks at the situational context and circumstantial evidence: self-defense.

C. Self-Defense

Self-defense is situational. That is, self-defense requires the court and fact finder to assess the entire context of a situation. For example, the Model Penal Code (“MPC”) bars the defense when “the actor, with the purpose of causing death or serious

not know or have reasonable grounds to foresee in taking such drugs that his mental condition would become such as to render him incapable of exercising such care in driving the automobile on the street at the time and place and would thereby endanger the lives and safety of persons thereon, you will find the defendant not guilty.”).

154. See *Jones v. State*, 648 P.2d 1251, 1257 (Okla. Crim. App. 1982) (In a case of lorazepam mixing with alcohol, the appeals court deferred to the jury.).

155. Cf. *TIFFANY & TIFFANY*, *supra* note 11, at 467–72 (discussing ambiguity in case law).

156. See James A. Macleod, *Belief States in Criminal Law*, 68 OKLA. L. REV. 497, 498 (2016) (“The law often requires fact-finders to use circumstantial evidence to determine another’s mental state.”).

bodily injury, provoked the use of force against” himself.¹⁵⁷ Intoxication—discussed above in Section IV.A—also often negates the defense.¹⁵⁸

Applying this doctrine to the noncompliant insanity case would provide firm doctrinal support to extend the insanity inquiry to the moment of noncompliance, provided the causal link between noncompliance and the crime could be established. Like the first two analogies considered, the inquiry becomes one of gauging the mental state of a mental patient when he decides to stop taking medication. The holistic inquiry for the “unmasking insanity” cases once again becomes relevant. Hence, self-defense helps justify the move to expand the time frame but provides little guidance on how to analyze the additional information gained from considering the time course before the crime.

The next defense, multiple personality, assumes that the expanded timeframe is required and provides a rubric with which to analyze an individual who is passing from sanity to insanity and potentially back again.

D. The “Multiple Personality” Defense

Although there has been some debate about the prevalence of dissociative identity disorder (one subtype is popularly known as multiple personality disorder), there is increasing evidence that it does exist in a subset of traumatized patients.¹⁵⁹ Indeed, the connection between dissociative identity disorder

157. MODEL PENAL CODE § 3.04(2)(b)(i) (AM. LAW INST., Proposed Official Draft 1962).

158. See Robinson, *supra* note 8, at 7–8; see also State v. Coyle, 67 S.E. 24, 27 (S.C. 1910) (“[V]oluntary intoxication is no excuse for crime . . .”).

159. See David Spiegel et al., *Dissociative Disorders in DSM-5*, 9 ANN. REVS. CLINICAL PSYCHOL. 299, 301 (2013) (“However, the persistence of solidly grounded clinical description and case series indicates that the disorder is more than an iatrogenic response to maladroit therapeutic suggestion.” (citations omitted)); see also A.A.T. Simone Reinders, *Cross-examining dissociative identity disorder: Neuroimaging and etiology on trial*, 14 NEUROCASE 44, 50 (2008) (“How can it be determined whether the origin of the subject’s DID is traumagenic, iatrogenic or pseudogenetic? Is the disorder genuine, subconsciously simulated or consciously malingered?”). See generally Elyn R. Saks, *Multiple Personality Disorder and Criminal Responsibility*, 25 U.C. DAVIS L. REV. 383 (1992) (for a more theoretical discussion and survey of earlier psychiatric literature).

and schizophrenia is beginning to be elucidated.¹⁶⁰ The non-compliant insanity defendant could be analyzed using a two-personality approach. The “host” represents a patient in psychotic remission, compliant with treatment. The “alternate” appears when medication is discontinued—and is most likely to commit a crime.¹⁶¹

Courts have adopted three approaches in dealing with multiple personality defenses: (1) the unified approach, in which the court considers the whole person without acknowledging the alleged multiple personalities inhabiting the same body; (2) the host approach, which focuses on whether the “host” personality could control the “alternate” personality at the time of the crime; and (3) the alter or “alternate” approach, which focuses on whether the “alternate” personality in control at the time of crime is insane.¹⁶² The unified approach does not acknowledge the existence of mental illness, which is not a particularly defensible approach when the inquiry is not whether the defendant has a mental illness, but whether he should be responsible for triggering it.¹⁶³ The host and alter approaches are more promising.

The host approach is typified by *United States v. Denny-Shaffer*.¹⁶⁴ The defendant, accused of kidnapping a baby from a

160. See Brad Foote & Jane Park, *Dissociative Identity and Schizophrenia: Differential Diagnosis and Theoretical Issues*, 10 CURRENT PSYCHIATRY REPS. 217, 221 (2008) (“We have presented a brief overview of current research and theory about the relationship between DID and schizophrenia, which is currently an area of much interest due to the extensive symptom overlap noted previously, combined with the increasing recognition that trauma’s role in shaping psychotic illness may be much greater than previously thought.”).

161. To be clear, “[t]he weight of the evidence to date is that although a statistical relationship does exist between schizophrenia and violence, only a small proportion of societal violence can be attributed to persons with schizophrenia.” Elizabeth Walsh et al., *Violence and schizophrenia: examining the evidence*, 180 BRIT. J. PSYCHIATRY 490, 494 (2002).

162. See Juliette K. Orr, *Multiple Personality Disorder and The Criminal Court: A New Approach*, 28 SW. U. L. REV. 651, 655–59 (1999); see also Mary Eileen Crego, Note, *One Crime, Many Convicted: Dissociative Identity Disorder and The Exclusion of Expert Testimony in State v. Greene*, 75 WASH. L. REV. 911, 922–25 (2000). See generally Sabra McDonald Owens, Note, *The Multiple Personality Disorder (MPD) Defense*, 8 MD. J. CONTEMP. LEGAL ISSUES 237 (1997) (collecting cases).

163. See Orr, *supra* note 162, at 658 (“In focusing on the whole person, it completely ignores the fact that the defendant has a mental disorder.”).

164. 2 F.3d 999 (10th Cir. 1993).

hospital and transporting him over state lines,¹⁶⁵ attempted to plead insanity on the basis of multiple personalities.¹⁶⁶ The Court of Appeals held that the defendant had made a prima facie case for insanity—but that the focus should be on whether the “host” personality was aware of the offense and its wrongfulness.¹⁶⁷ Likewise, in the noncompliant insanity case, the question would be whether the defendant—in a medicated, “more sane” “host” state—understood the consequences of discontinuing medication. This could be a very fact-intensive and expert-heavy inquiry into the state of mind of a defendant.

In contrast, the alter approach would be simpler and would reduce to the approach of merely looking at the immediate time frame of the crime. In *State v. Rodrigues*,¹⁶⁸ the Supreme Court of Hawaii contended with a defendant who argued that he had sodomized and raped young girls while in another personality.¹⁶⁹ Although the court remanded for technical reasons, it directed that insanity be assessed at the time of the crime:

The cases dealing with [Multiple Personality Disorder] can be examined in a similar fashion as other defenses of insanity. If a lunatic has lucid intervals of understanding he shall answer for what he does in those intervals as if he had no deficiency. The law governs criminal accountability where at the time of the wrongful act the person had the mental capacity to distinguish between right and wrong or to conform his conduct to the requirements of the law. Since each personality may or may not be criminally responsible for its acts, each one must be examined under [Hawaii’s insanity standard at the time].¹⁷⁰

In the noncompliant insanity context, this approach comports well with the tact taken by the courts in *Shin*, *Samuels*, and *McCleary* as the focus is on the “alternate” or noncompliant personality in control at the time of the crime. Such an approach, however, ignores the “host” or “sane” personality’s

165. *Id.* at 1002.

166. *See id.* at 1012–17.

167. *See id.* at 1019 (“On the other hand, there is substantial evidence that raises an insanity defense for the defendant, viewed as the host personality, respecting such confining or holding the baby after the abduction.”).

168. 679 P.2d 615 (Haw. 1984).

169. *Id.* at 617–18.

170. *Id.* at 618.

role in triggering insanity—if indeed the medication-compliant patient had any control over stopping medication.

Although the multiple personality approach provides further support for expanding the timeframe of the insanity inquiry and bolsters considering what the “sane” or medication-compliant defendant does before going off medication, it leaves us with another problem: how much control the defendant in remission had over discontinuing medication. But this is an acceptable inquiry, because it is the same one that capped the theoretical discussion in Part III and many of the previous analogies considered. And at core, courts must confront this issue. Before turning to the conclusion, the next section will discuss some defenses that might superficially aid the inquiry but actually ask the same questions of other parts or do not add much to the analysis.

E. Less Useful Defenses

This section surveys some potential candidates for analogies that do not advance the inquiry.

At first, the little-used defenses of amnesia, automatism, and duress seem to shed light on the issue of noncompliant insanity. But they simply ask different questions—with equally difficult answers—of the same time frames that are considered above. Amnesia inquires whether the defendant remembers the events in question.¹⁷¹ The doctrine provides little insight into

171. The question in these cases is often whether the defendant is fit to stand trial if he cannot remember the events in question. *See, e.g.*, *United States v. Stevens*, 461 F.2d 317, 320 (7th Cir. 1972) (“We believe that the only theory by which the defendant could be found on this record to have been incompetent to stand trial would be that incompetence requires no more than the present inability to recall the events of one’s life during the period of the commission of a crime with which one is charged. Moreover, we do not believe that due process requires that every defendant who claims loss of memory go free without trial.”); *Wilson v. United States*, 391 F.2d 460, 463 (D.C. Cir. 1968) (Skelly Wright, J.) (“We agree with Judge McGuire’s general approach to assessing the question of competency. However, we remand to the trial judge for more extensive post-trial findings on the question of whether the appellant’s loss of memory did in fact deprive him of the fair trial and effective assistance of counsel to which the Fifth and Sixth Amendments entitle him.”); *United States v. Hearst*, 412 F. Supp. 858, 861 (N.D. Cal. 1975) (“But even if Dr. West is correct in his diagnosis that the defendant’s memory is so impaired as to prevent her from relating the events of her life during the period of the alleged commission of the crime, such amnesia would not alone constitute sufficient grounds for a finding of incompetency to stand trial.”);

whether to focus on the crime itself or the decisions surrounding noncompliance with medication and does not provide any easier inquiries into these events. Similarly, automatism or unconsciousness¹⁷² asks if the defendant had voluntary control over his actions, which is similar to the question posed in insanity cases.¹⁷³ Common law duress presents a similar problem (and recapitulates many of the same issues that were relevant in self-defense), for although it does consider actions before the criminal act, it provides little insight into whether internal mental illness is coercive.¹⁷⁴

Despite these doctrinal dead ends, courts and the criminal law must resolve cases that come in—even without a clear sci-

People v. Stahl, 2014 IL 115804, ¶ 27 (“The issue of whether a defendant’s amnesia as to the events surrounding the crime *per se* renders him unfit to stand trial is one of first impression before this court.”). However, sometimes amnesia is used to negate intent. *See, e.g.*, *Tatum v. United States*, 190 F.2d 612, 617 (D.C. Cir. 1951) (Bazelon, J.) (“We do not intend to characterize the case for the defense as either strong or weak. That is unnecessary, for ‘in criminal cases the defendant is entitled to have presented instructions relating to a theory of defense for which there is any foundation in the evidence, even though the evidence may be weak, insufficient, inconsistent, or of doubtful credibility. He is entitled to have such instructions even though the sole testimony in support of the defense is his own.’” (citation omitted)); *United States v. Marriott*, 15 C.M.R. 390, 392–93 (1954) (“Amnesia due to alcoholism is a possibility also relevant to the instant case—for it is admitted that the accused and his comrades were to some extent under the influence of intoxicating liquor.” (citation omitted)). *See generally* Note, *Amnesia: A Case Study in the Limits of Particular Justice*, 71 YALE L.J. 109 (1961).

172. *See, e.g.*, *People v. Grant*, 377 N.E.2d 4, 8 (Ill. 1978) (“A person in a state of automatism lacks the volition to control or prevent the involuntary acts. Such involuntary acts may include those committed during convulsions, sleep, unconsciousness, hypnosis or seizures.”). *See generally* Michael Corrado, *Automatism and The Theory of Action*, 39 EMORY L.J. 1191 (1990); Sanford J. Fox, *Physical Disorder, Consciousness, and Criminal Liability*, 63 COLUM. L. REV. 645 (1963); F.M. Kamm, *Action, Omission, and The Stringency of Duties*, 142 U. PA. L. REV. 1493 (1994); Kevin W. Saunders, *Voluntary Acts and The Criminal Law: Justifying Culpability Based on The Existence of Volition*, 49 U. PITT. L. REV. 443 (1988).

173. However, despite the similarity in the defenses for the purposes of this paper, they are distinct. *See, e.g.*, *State v. Caddell*, 215 S.E.2d 348, 360 (N.C. 1975) (“The defenses of insanity and unconsciousness are not the same in nature, for unconsciousness at the time of the alleged criminal act need not be the result of a disease or defect of the mind. As a consequence, the two defenses are not the same in effect, for a defendant found not guilty by reason of unconsciousness, as distinct from insanity, is not subject to commitment to a hospital for the mentally ill.”).

174. *See generally* Steven J. Mulroy, *The Duress Defense’s Uncharted Terrain: Applying it to Murder, Felony Murder, and The Mentally Retarded Defendant*, 43 SAN DIEGO L. REV. 159 (2006); L.I. Reiser, Annotation, *Coercion, compulsion, or duress as defense to criminal prosecution*, 40 A.L.R.2d 908 (1955).

entific understanding of the mental diseases from which defendants potentially suffer. The conclusion begins to sketch a way forward.

V. CONCLUSION

In considering how to treat noncompliant insanity, it is important to make an individualized assessment of each defendant. Because around 50% of schizophrenics lack insight into their disease, criminally punishing people for noncompliance *who do not know they have a mental disease* seems to punish those who neither deserve sanction nor will respond to it. Criminal commitment seems like the better way in those cases. But returning to the problem posed in the introduction of this paper, what to do about those with insight? After all, “insanity must be the result of circumstances beyond the control of the actor.”¹⁷⁵ Again, the inquiry must be individualized as far as possible. The easiest—and rarest—case is the schizophrenic patient who understands that he is sick, requires treatment for that illness, and needs medication to ensure that he does not do anything dangerous. If some external factor (such as cost, work schedule, or distraction) is what stands between a patient and compliance, then how many excuses will the law allow in?¹⁷⁶ If some internal factor (for instance, exacerbation of the disease) is at issue, then the case for allowing insanity in becomes much stronger.

In the face of scientific and medical uncertainty, a *per se* rule that confines the inquiry to the events immediately surrounding the crime, and that does not encompass what happened

175. *United States v. Henderson*, 680 F.2d 659, 664 (9th Cir. 1982) (citing *United States v. Burnim*, 576 F.2d 236, 238 (9th Cir. 1978)).

176. *Cf. United States v. Alexander*, 471 F.2d 923, 968 (D.C. Cir. 1972) (McGowan, J., dissenting) (“Judge Bazelon also finds reversal to be compelled by reason of a statement made to the jury by the court in the course of its instructions. The bare words used are not a faulty statement of the law. They remind the jury that the issue before them for decision is not one of the shortcomings of society generally, but rather that of appellant Murdock’s criminal responsibility for the illegal acts of which he had earlier been found guilty; and, the court added in the next breath, that issue turns on ‘whether [appellant] had an abnormal condition of the mind that affected his emotional and behavioral processes at the time of the offense.’ This last is, of course, an unexceptionable statement of what we have declared to be the law in this jurisdiction.” (alterations in original)).

with medication—as adopted in *Shin*, *Samuels*, and *McCleary*—may be easier to administer and lead to fewer mistakes than an individualized, multi-factor approach for every defendant who makes it to trial.¹⁷⁷ Especially considering that a successful insanity defense leads to criminal commitment with potential treatment, it is not clear that defendants would attempt to game the system under a per se rule system (being committed to a criminal mental facility is not exactly a win for the defendant, though defendants may have individual preferences). Also, courts and the experts who inform them are not yet ready to opine on these individualized and complex issues.

This state of affairs is not unprecedented. Attempting to grapple with at least one physician's view of the world, one court, in 1965, cautioned that a particular scientific fad or idiosyncrasy need not leave an imprint on the law:

If the law were to accept [the defense expert's] medical doctrine as a basis for a finding of second rather than first degree murder, the legal doctrine of *mens rea* would all but disappear from the law. Applying [the defense expert's] theory to crimes requiring specific intent to commit, such as robbery, larceny, rape, etc., it is difficult to imagine an individual who perpetrated the deed as having the mental capacity in the criminal law sense to conceive the intent to commit it. Criminal responsibility, as society now knows it, would vanish from the scene, and some other basis for dealing with the offender would have to be found. At bottom, this would appear to be the ultimate aim of the psychodynamic psychiatrists.¹⁷⁸

That same court opted to consider the medical theory in the sentencing phase of the trial.¹⁷⁹ Although that option is open in the noncompliant insanity cases, that solution poses challenges.

177. Cf. ADRIAN VERMEULE, JUDGING UNDER UNCERTAINTY: AN INSTITUTIONAL THEORY OF LEGAL INTERPRETATION 219 (2006) ("Most surprisingly, rules might sometimes reduce error on the part of lower-court judges even though rules are overinclusive and underinclusive relative to the rules' background justifications.").

178. *State v. Sikora*, 210 A.2d 193, 203 (N.J. 1965) (citation omitted).

179. *See id.* at 204 ("In the prosecution of accused for noncapital crimes similar use should be made of the type of medical opinion relied upon here. Under our present system, such psychiatric testimony properly serves a postconviction purpose. It may be included in the pre-sentence probation report or submitted to the sentencing judge in any other suitable fashion. If in his judgment and discretion it reveals limited criminal blameworthiness, such fact may be reflected in the sentence.").

It is simply no answer to say that which we do not consider in liability becomes yet another factor in sentencing. Such a dodge makes sentencing too multi-factorial and opens the way for arbitrariness to leak in. Although emergent theories may have a role initially in sentencing, there needs to be a reprocessing of the science and consideration of what can graduate from sentencing to liability—and what theories need to be consigned to the dustbin of history.¹⁸⁰

Indeed, these temporary resolutions ought not be permanent.¹⁸¹ As we learn more about schizophrenia and other mental diseases, it should become necessary to reexamine the per se rule. Perhaps the per se rule was right all along; or perhaps not. It is likely that courts will find some defendants who have the insight to understand that stopping antipsychotic medications, like discontinuing antiepileptic medications, can have dramatic consequences. Nonetheless, noncompliant insanity provides a fascinating and critical example of where neuroscience may soon be able to help inform the law—and will hopefully continue the conversation between the courts and experts in shaping the insanity defense.

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180. *Cf. Commonwealth v. Campbell*, 284 A.2d 798, 802 (Pa. 1971) (Pomeroy, J., concurring) (“I agree that, at this stage of our scientific knowledge, the appellant’s voluntary ingestion of hallucinogenic drugs, and his resultant disorientation, should be likened to voluntary intoxication and not to legal insanity. I thus concur in the opinion of the Court that the trial judge committed no error in so presenting the issue to the jury.”).

181. The Court has recognized that per se rules can be problematic—especially in neuroscience. *See Roper v. Simmons*, 543 U.S. 551, 588 (2005) (O’Connor, J., dissenting) (“Adolescents as a class are undoubtedly less mature, and therefore less culpable for their misconduct, than adults. But the Court has adduced no evidence impeaching the seemingly reasonable conclusion reached by many state legislatures: that at least some 17-year-old murderers are sufficiently mature to deserve the death penalty in an appropriate case. Nor has it been shown that capital sentencing juries are incapable of accurately assessing a youthful defendant’s maturity or of giving due weight to the mitigating characteristics associated with youth.”).