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CRIMINAL RESPONSIBILITY AND THE NONCOMPLIANT PSYCHIATRIC OFFENDER: RISKING MADNESS

A criminal offender who suffers from mental illness and satisfies the requirements of the insanity defense at the time of an offense is normally exculpated. Often though, the symptoms of mental illness present at the time of the offense are a direct consequence of an offender's failure to take psychotropic medication. The Author argues that psychiatric patients who consciously decide not to take their medication and are aware of the consequences of such a decision, should be barred from relying on an insanity defense when they suffer a relapse and commit a crime while mentally ill. Moreover, the Author argues that when noncompliance amounts to recklessness, it could give rise to criminal responsibility under the reckless endangerment approach of the Model Penal Code.

THE USE OF medication to control the presence and severity of symptoms of mental illness has become a common occurrence in psychiatric treatment.¹ Medication can, in many cases, alleviate the symptoms commonly associated with severe mental illness such as delusions and hallucinations. Once restored to reason, the patient may be given the responsibility of administering his own medication. Yet, as a group, only 50 percent of the mentally ill will comply with long-term medication treatment.² For those that choose not to comply, 80 out of 100 are likely to relapse into illness within 2 years.³ One might wonder whether choosing not to comply in light of such a high risk of relapse amounts to reckless-

1. "A widely-held belief about modern-health care is that [antipsychotic] drugs, introduced in the mid-1950s, brought a new dawn to psychiatry, making possible effective treatment and community care for psychotic patients. Chlorpromazine, the first of the antipsychotic drugs, initiated a 'therapeutic revolution' in the . . . treatment of schizophrenia. . . ." R. WARNER, *RECOVERY FROM SCHIZOPHRENIA* 80 (1985). *But cf.* C. KEISLER & A. SIBULKIN, *MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS* 48-69 (1987) (pointing out other influential trends in the therapeutic 'revolution' of mental illness).

2. See Sackett & Snow, *The Magnitude of Compliance and Noncompliance*, in *COMPLIANCE IN HEALTH CARE* 11, 14 (1979).

3. See Johnson, *Observations on the Use of Long-Acting Depot Neuroleptic Injections in the Maintenance Therapy of Schizophrenia*, 45 *J. CLIN. PSYCHIATRY* 13, 14-15 (1984).

ness especially if the decision is made repeatedly and the result is always a relapse. Furthermore, the proclivity to act antisocially while in a relapsed state of mental illness would exponentially increase the risk to society.⁴ If noncompliance⁵ with treatment occurs, under what circumstances should the decision to become noncompliant and 'risk madness' constitute inculpatory conduct? This presents a challenging question about criminal responsibility and insanity.⁶ If culpably causing the conditions of one's defense bars reliance on that incapacity,⁷ should the noncompliant mentally ill offender be allowed to rely on the insanity defense after risking madness?

The insanity defense⁸ is designed to protect those who are not

4. See *infra* notes 184-222 and accompanying text. See generally *Carlisle v. State*, 512 So. 2d 150, 153-54 (Ala. Crim. App. 1987) (noncompliant schizophrenic kills his brother); *State v. Johnson*, 156 Ariz. 464, 465, 753 P.2d 154, 155 (1988) (noncompliance by schizophrenic results in death of neighbor); *People v. Chavez*, 629 P.2d 1040, 1043-45 (Colo. 1981) (defendant with chronic schizophrenia had a long history of criminal conduct and multiple previous hospitalizations for noncompliance); *Naidu v. Laird*, 539 A.2d 1064, 1066-69 (Del. 1988) (noncompliant schizophrenic causes death while in psychotic state); *Warner v. State*, 301 Minn. 333, 343-45, 244 N.W.2d 640, 647 (1976) (first degree murder acquittee with schizophrenia denied release because her illness, held in remission by medication, might relapse with foreseeable risk of harm); *Tobis v. State*, 52 Wash. App. 150, 152, 758 P.2d 534, 535 (1988) (Following an acquittal on grounds of insanity for murdering his wife, the acquittee was unconditionally released from an institution and subsequently killed two others.).

5. Noncompliance with treatment is defined as the extent to which a person's behavior, in terms of taking medications, does not coincide with medical or health advice. HAYNES, *Introduction, in COMPLIANCE IN HEALTH CARE*, *supra* note 2, at 1-2; see also Waller & Altshuler, *Perspectives on Patient Noncompliance*, 37 HOSP. & COMMUNITY PSYCHIATRY 490 (1986) (providing an identical definition).

6. The role of noncompliance as it might affect criminal responsibility was apparently first broached by Sherlock, *Compliance and Responsibility: New Issues for the Insanity Defense*, 12 J. PSYCHIATRY & L. 483 (1984). This Note expands on Sherlock's hypothesis that noncompliance may have an important role to play in determining criminal responsibility.

7. See, e.g., 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) [hereinafter Robinson, *Causing the Conditions*].

8. This Note will use the definition of the insanity defense as found in the Model Penal Code. (All references to the Code are to the 1962 Official Draft and Revised Comments). The Model Penal Code defines the insanity defense as:

- (1) 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 the substantial capacity to either appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law. (2) As used in this Article, the terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

MODEL PENAL CODE § 4.01 [hereinafter cognitive and volitional prongs of the insanity defense, or insanity defense]. Many jurisdictions have adopted the Model Penal Code test

blameworthy from criminal condemnation.⁹ Those that do not have the capacity to engage in moral reasoning or the capacity to direct their volition as a result of a mental illness are believed to lack the attributes of sanity and are viewed as lacking criminal responsibility.¹⁰ In addition, subjecting insane individuals to criminal responsibility for their acts does not serve the principles behind punishment.¹¹ Most often, as long as the actor fulfills the requirements for insanity, he will be relieved of criminal responsibility.¹² The validity of the insanity defense largely depends on the presence or absence of an identifiable mental disease and its impact on cognitive and volitional capacity, and very little attention is accorded to the antecedent acts of the mentally ill offender.¹³ Ignoring factors that contribute to the existence of the mental illness, specifically noncompliance with treatment,¹⁴ is contrary not only to the judicial disposition of other self-induced incapacities like voluntary intoxication and epilepsy but also to the theories behind the insanity defense and the goals of the criminal law.

This Note will explore the relevance of the psychiatric patient's noncompliance with treatment as it effects his responsibility for criminal liability. Part IA will outline the principles underlying criminal responsibility and the insanity defense.¹⁵ Part IB will explore judicial treatment of voluntarily induced incapacities - epilepsy and intoxication - and their effect on criminal responsibil-

for the insanity defense in substantially similar form, and while variations do exist, they generally employ the following elements: "(1) presence of a mental disease or defect, (2) lack of cognition, and (3) lack of volition." *People v. Grant*, 46 Ill. App. 3d 125, 133, 360 N.E.2d 809, 816 (1977), *rev'd*, 71 Ill. 2d 551, 377 N.E.2d 4 (1978). For a survey of jurisdictions using the Model Penal Code test, its variations, as well as other variations, see Annotation, *Modern Status of Test of Criminal Responsibility - State Cases*, 9 A.L.R. 4TH 526 (1987); Annotation, *Modern Status of Test of Criminal Responsibility - Federal Cases*, 56 A.L.R. FED. 326 (1982 & Supp. 1988).

9. See *infra* notes 27-67 and accompanying text.

10. See *infra* notes 54-67 and accompanying text.

11. See *infra* notes 31-34, 54, 56 and accompanying text.

12. See *infra* notes 54-63 and accompanying text.

13. See *infra* notes 184-222 and accompanying text.

14. This Note deals exclusively with medication noncompliance by psychiatric patients (schizophrenics). For articles dealing with causes of one's incapacity and the effect on criminal responsibility, see Mitchell, *The Intoxicated Offender-Refuting the Legal and Medical Myths* 11 INT'L J. L. & PSYCHIATRY 77 (1988) [hereinafter Mitchell, *The Intoxicated Offender*]; Mitchell, *Culpable Mental Disorder and Criminal Liability*, 8 INT'L J. L. & PSYCHIATRY 273 (1986) [hereinafter Mitchell, *Culpable Mental Disorder*]; Robinson, *Causing the Conditions*, *supra* note 7; Sellers, *Mens Rea and the Judicial Approach to "Bad Excuses" in the Criminal Law*, 41 MOD. L. REV. 245 (1978).

15. See *infra* notes 27-72 and accompanying text.

ity.¹⁶ Part IB will also expose how criminal responsibility is imposed where an incapacity is self-induced.¹⁷ Part IC discusses the clinical course of schizophrenia and how medication noncompliance is similar to a self-induced psychosis.¹⁸ Part ID addresses how courts currently view medication noncompliance.¹⁹

Part II offers a paradigm case for analysis - a noncompliant schizophrenic offender with a 17-year history of mental illness and repeated criminal conduct.²⁰ An examination of the policy reasons behind the insanity defense and the judicial treatment of other self-induced incapacities²¹ will demonstrate that allowing the exculpation of noncompliant self-induced mental illness is contrary to the rationale behind the insanity defense and the principles of criminal responsibility. In addition, Part II will examine the relevance of indigency,²² incompetency,²³ intolerance of medication,²⁴ inefficacious treatment,²⁵ and stress-induced relapse,²⁶ as they effect criminal responsibility in this context. This Note will conclude that, in some circumstances, imposing responsibility on the noncompliant mentally ill criminal offender is consistent with the aims of criminal law and with accepted principles of criminal responsibility. When the noncompliant offender was aware of a substantial and unjustifiable risk of death or serious bodily harm but consciously disregarded that risk, he should be held responsible for risking madness under the reckless endangerment approach of the Model Penal Code. In the event harm occurs, the offender should be denied the protection of the insanity defense and should be held responsible for the resulting harm.

16. See *infra* notes 73-149 and accompanying text.

17. *Id.*

18. See *infra* notes 150-183 and accompanying text.

19. See *infra* notes 184-222 and accompanying text.

20. See *infra* notes 223-66 and accompanying text.

21. This Note will draw on cases dealing with epileptics who have seizures as a result of their noncompliance with antiseizure medication as well as voluntarily intoxicated offenders. See *infra* notes 73-94 and accompanying text for the discussion of epilepsy and *infra* notes 95-148 and accompanying text for the discussion of intoxication.

22. See *infra* notes 268-70 and accompanying text.

23. See *infra* notes 271-75 and accompanying text.

24. See *infra* notes 276-78 and accompanying text.

25. See *infra* notes 279-80 and accompanying text.

26. See *infra* note 281 and accompanying text.

I. EXCULPATION & INCULPATION

A. Criminal Responsibility and Insanity: Exculpation²⁷

In our society, we assume that all adults are sane and responsible for their conduct.²⁸ The criminal law serves to protect individuals from harm by enforcing established standards of conduct which regulate communal existence.²⁹ When conduct is defined as criminal, it will reflect a social consensus that the conduct denigrates social order and cannot be tolerated in a community.³⁰ Those that violate criminal laws become subject to direct social control in the form of punishment.³¹ Punishment of criminal offenders serves to deter the individual and others from engaging in

27. See generally H. FINGARETTE, *THE MEANING OF CRIMINAL INSANITY* 2 n.5 (1972) ("A tradition of chronic imprecision in the elucidation of principles of criminal responsibility has existed in the common-law world for seven centuries.") (quoting Dubin, *Mens Rea Reconsidered: A Plea For a Due Process Concept of Responsibility*, 18 *STAN. L. REV.* 323, 324 (1966)); Weinreb, *Desert, Punishment and Criminal Responsibility*, *LAW & CONTEMP. PROBS.*, Summer 1986, at 47, 58-59, 79 (which factors are given greatest weight, and what the parameters of the various factors are, is unclear).

28. *People v. Chavez*, 629 P.2d 1040, 1047 (Colo. 1981); see also A. GOLDSTEIN, *THE INSANITY DEFENSE* 16-17 (1967) ("The law assumes for most situations that all men have the necessary qualities to make the expected responses . . . [and] is reflected in the presumption that all men are sane and that they intend the natural and probable consequences of their acts."); F. WINSLOW, *THE PLEA OF INSANITY IN CRIMINAL CASES* 3 (1843):

We seem generally to start with a model of responsible action defined not by the nature of the act but by reference to the notion of a person, an abstraction loosely associated with an adult human being identified as such by physical characteristics alone. In the absence of special excusing circumstances, that model is presumed to be applicable, and the attribution is taken for granted.

Weinreb, *supra* note 27, at 58.

29. PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND THE ADMINISTRATION OF JUSTICE, *THE CHALLENGE OF CRIME IN A FREE SOCIETY* 7 (1967), reprinted in S. KADISH, S. SCHULHOFER & M. PAULSEN, *CRIMINAL LAW AND ITS PROCESSES*, at 1 (4th ed. 1983).

30. See, e.g., MODEL PENAL CODE § 1.02(1)(a); see also *infra* note 33.

31. *State v. Breakiron*, 108 N.J. 591, 598, 532 A.2d 199, 202 (1987) ("[I]t is the distinctive feature of the penal law that it condemns offenders as wrongdoers, marshalling the formal censure of conviction and coercive sanctions on this ground.") (quoting Wechsler, *Codification of Criminal Law in the United States: The Model Penal Code*, 68 *COLUM. L. REV.* 1425, 1434 (1968)). Punishment of those who have not shown the ability to conform serves to promote social order.

Harmony may be achieved by emphasizing the balance that must be struck between society's demand for maximum conformity to the prohibitions of the criminal law and the individual's just expectation not lightly to be deprived of his liberty, and by recognizing as the most significant element in striking this balance the liability on conviction to imprisonment.

Sellers, *supra* note 14, at 247.

criminal conduct in the future.³² It also serves to equalize harm by "exacting the debt" owed to society³³ as well as to rehabilitate criminal offenders so that they may rejoin society and conform to established standards of conduct.³⁴ In order to ensure that only the blameworthy are punished and that punishment is meted out in accord with one's blameworthiness, criminal offenses are defined in terms of both acts and states of mind.³⁵ Thus, punishment for blameworthy conduct occurs only if done voluntarily and with a guilty mind.³⁶ When these two conditions are fulfilled, criminal responsibility exists and punishment is appropriate.³⁷

32. General and special deterrence theories are often used as justification for the infliction of punishment. They also serve to justify withholding punishment from the insane.

Under the deterrent theory . . . the primary function of criminal law is to move men to conform to social norms, particularly those which cannot be left entirely to informal processes of social control If a man cannot make the calculations or muster the feelings demanded of him by the theory, he is classed as insane If he were held criminally responsible, he would be made to suffer harsh sanctions without serving the purpose of individual [or societal] deterrence.

A. GOLDSTEIN, *supra* note 28, at 12-13.

33. H. MORRIS, ON GUILT AND INNOCENCE 33-34 (1976), *reprinted* in S. KADISH, S. SCHULHOFFER & M. PAULSEN, CRIMINAL LAW AND ITS PROCESSES, at 188-189 (4th ed. 1983) (a retributivist position would justify the insanity defense by proposing to equalize harm through "forgiveness of the debt" owed to society).

34. Radzinowicz & Turner, *A Study of Punishment I: Introductory Essay*, 21 CANADIAN B. REV. 91, 91-97 (1943), *reprinted* in S. KADISH, S. SCHULHOFFER & M. PAULSEN, CRIMINAL LAW AND ITS PROCESSES, at 203-205 (4th ed. 1983). It is believed that the insane are more appropriately rehabilitated by applying mental health laws rather than criminal laws. Morris, *The Criminal Responsibility of the Mentally Ill*, 33 SYRACUSE L. REV. 477, 479-80 (1982); *see also*, MODEL PENAL CODE § 4.01 comment 1 (pointing out the need for a "working line between the authorities responsible for public health and those responsible for the correction of offenders").

35. *People v. Chavez*, 629 P.2d 1040, 1046 (Colo. 1981). Requiring both an act and a state of mind serves to ensure that conduct punished as criminal is morally justified. The Model Penal Code lists five purposes governing offense definitions:

(a) to forbid and prevent conduct that unjustifiably and inexcusably inflicts or threatens substantial harm to individual or public interests; (b) to subject to public control persons whose conduct indicates that they are disposed to commit crimes; (c) to safeguard conduct that is without fault from condemnation as criminal; (d) to give fair warning of the nature of the conduct declared to constitute an offense; (e) to differentiate on reasonable grounds between serious and minor offenses.

MODEL PENAL CODE § 1.02. Each purpose serves to ensure that when conduct is punished, society can justly sit in condemnation of the actor. Bazelon, *Morality and the Law*, 13 AUSTRALIAN J. FORENSIC SCI. 2, 2-4 (1980) [hereinafter Bazelon, *Morality*].

36. *See, e.g.*, MODEL PENAL CODE §§ 2.01-2.02 (requirement of voluntary act and general requirements of culpability).

37. *State v. Breakiron*, 108 N.J. 591, 596, 532 A.2d 199, 201 (1987) ("a voluntary

Underlying the requirements of blameworthy conduct is the principle that human behavior occurs as a result of the free choice of the actor.³⁸ When exercising free choice, the actor's conduct is viewed as the result of his will.³⁹ Consequently, when the actor chooses to act in a morally reprehensible manner which is censurable by law, the actor becomes an appropriate subject for punishment.⁴⁰ If the actor's conduct is determined by factors beyond his control, he will not be held criminally responsible for any harm done while in such a state.⁴¹

A necessary corollary to the principle that behavior occurs as a result of free choice is the notion that human beings have the capacity to reason.⁴² The responsible actor will have the capacity

act and a culpable state of mind [are] the minimum conditions for liability"); *State v. Caddell*, 287 N.C. 266, 295, 215 S.E.2d 348, 366 (1975) (Sharp, Chief J., concurring in result and dissenting in part) (a voluntary act is an "absolute requirement for criminal liability"); *see also*, *State v. Mishne*, 427 A.2d 450, 458 (Me. 1981) ("To be voluntary an act must be the result of an exercise of a defendant's conscious choice to perform them, and not the result of reflex, convulsion, or other act over which a person had no control. . .").

38. *United States v. Brawner*, 471 F.2d 969, 995 (D.C. Cir. 1972) ("Our jurisprudence . . . ultimately rests on a premise of freedom of will."); *cf.* MODEL PENAL CODE § 2.01 (stating that criminal liability requires a voluntary act of omission); Weinreb, *supra* note 27, at 57 (argues that human beings are autonomous and their conduct is self-determined, although strongly affected by personal history and characteristics. Otherwise, the concept of desert is meaningless.). For a critique of the assumption that human behavior is governed by freewill, see Norrie, *Freewill, Determinism and Criminal Justice*, 3 LEGAL STUD. 60 (1983). For a pragmatic response, see Delk, *The Insanity Defense: Free Will, Determinism, and the Legal Process*, 21 PROSECUTOR 29 (1988).

39. 4 W. BLACKSTONE, Commentaries *21, reprinted in S. KADISH, S. SCHULHOFER & M. PAULSEN, CRIMINAL LAW AND ITS PROCESSES, at 258 (4th ed. 1983); Norrie, *supra* note 38, at 61.

40. Weinreb, *supra* note 27, at 56:

[We] presuppose that a person is responsible for his conduct and desert can attach only insofar as the conduct is self determined, and that whether conduct is self-determined or not is a matter of fact. An attribution of desert requires that a person have exercised a capacity to direct his actions for himself (even if by taking no action).

41. This proposition is often stated in the reverse in the context of the insanity defense. For example, in *United States v. Shuckahosee*, 609 F.2d 1351, 1355 (10th Cir. 1979), the court stated the maxim that "[f]or the insanity defense to be available, the mental condition must have been brought about by circumstances beyond the control of the defendant."

42. "If a man was deprived of all power of reasoning, so as not to be able to distinguish whether it was right or wrong to commit the most wicked or the most innocent transaction, he could not certainly commit an act against the law." F. WINSLOW, *supra* note 28, at 3 (quoting Lord Mansfield); *see also* Norrie, *supra* note 38, at 63 (an act committed while the actor is provoked or insane is not punishable because the act flows from the actor's loss of self control).

to weigh the consequences of his acts before deciding between different avenues of action.⁴³ Individuals who freely choose to act in a way that leads to individual or social harm are assumed to have reasoned that individual gain is more important than harmful consequences to society. These individuals are appropriate subjects for punishment.⁴⁴ However, those who lack the capacity to reason as a result of factors beyond their control are not appropriate subjects for punishment.⁴⁵

Further, presuming that an actor's conduct is governed by free choice and that behavior is chosen rationally, it necessarily follows that individuals have the capacity to know right from wrong and the capacity to control their own behavior.⁴⁶ The capacity to make a moral choice, that is the ability to discern right from wrong in a given set of circumstances, provides a basis for establishing that upon the occurrence of a moral wrong, blame or fault appropriately attaches.⁴⁷ Given that an actor has the capacity to know right from wrong, it is further assumed that the actor's conduct is the end product of his moral reasoning process.⁴⁸ An actor must have the capacity to direct volition in a manner consistent with his reasoning.⁴⁹ Where the actor lacks these capacities because of factors beyond his control, it would be inappropriate to hold him responsible or to punish him for his harmful conduct.

Only when conduct is a result of reasoned choice and reflects individual will may it be found blameworthy or culpable.⁵⁰ Where the individual's conduct is culpable, a violation of the criminal law

43. See Norrie, *supra* note 38, at 66.

[A] choosing being . . . can weigh the cost to him of obeying the law - and of sacrificing some satisfaction in order to obey - against obtaining that satisfaction at the cost of paying 'the penalty.' . . . [W]here they gain satisfaction from breaking the law, they must pay the price of that satisfaction. Where they forego that satisfaction, there is 'no charge'.

44. W. BLACKSTONE *supra* note 38, at 258; Norrie, *supra* note 38, at 66.

45. See *supra* note 41 and accompanying text.

46. The cognitive and volitional prongs of the insanity defense correspond to these capacities. See MODEL PENAL CODE § 4.01.

47. W. LAFAVE & A. SCOTT, CRIMINAL LAW § 4.2 (2d ed. 1972).

48. See A. GOLDSTEIN, *supra* note 28, at 17 ("all men are sane and . . . they intend the natural and probable consequences of their acts"); see also MODEL PENAL CODE § 4.01 (volitional prong); W. LAFAVE & A. SCOTT, *supra* note 47.

49. "A crucial assumption of the freewill model is that in order for actions to be free, they must be undertaken by a rational actor, that is, by one whose reason controls and directs his actions." Norrie, *supra* note 38, at 63.

50. See MODEL PENAL CODE § 4.01 comment 1.

will warrant punishment.⁵¹ Unless the presumptions underlying our notions of responsibility are questioned, the actor will be held responsible for the criminal offense.⁵² Those factors that serve as a basis for criminal responsibility, if absent, also serve as justification for having an insanity defense.⁵³

Relying on cognitive and volitional capacities, the insanity defense embodies circumstances where we believe the attributes of individual responsibility are no longer present.⁵⁴ The insanity defense represents an acknowledgement that the legally presumed prerequisites for criminal responsibility - free will, rationality, and cognitive and volitional capacities - may occasionally not exist.⁵⁵ By providing an insanity defense where a mental disease or defect renders the actor incapable of exercising reasoned choice or subverts volition such that conduct no longer reflects individual will, we are acknowledging that the presence of certain mental diseases can render one a mere agent of his illness.⁵⁶ We presume that the actor can do nothing to direct his own thoughts, nor can he do anything to control his own conduct. We presume that his nature is so different from most that he cannot be held to the same stan-

51. *Id.* at § 1.02(a) comment 2(a).

52. *See* Weinreb, *supra* note 27.

53. *See* A. GOLDSTEIN, *supra* note 28, at 89 (“[The law] has generally defined [the defense] by reference to the functions of the criminal law.”).

54. One court stated that:

The purpose of the insanity defense is to ensure that the criminal sanction is imposed only on those who had the cognitive and volitional capacity to comply with the law. Persons whose mental disorders deprive them of this capacity are neither culpable or deterrable, and thus “ought not to be subject to the same penalties or treatments as are justly meted out to those who are sane.”

Robey v. State, 54 Md. App. 60, 73, 456 A.2d 953, 960 (Md. Ct. Spec. App. 1983) (citations omitted) (quoting *Devilbiss v. Bennett*, 70 Md. 554, 556, 17 A. 502, 503 (1889)).

55. *State v. Breakiron*, 108 N.J. 591, 616, 532 A.2d 199, 203-04 (1987) (“[T]he [insanity defense] refers to evidence that, in theory, affects the presence of essential mental elements of the crime.”).

56. Moore, *Causation and the Excuses*, 73 CALIF. L. REV. 1091, 1137, 1138, 1149 (1985).

Because it is widely assumed that “blame” plays a critical role in maintaining individual responsibility and social order, the insanity defense . . . becomes the occasional device through which an offender is found to be inappropriate for the social purposes served by the criminal law [retribution, deterrence, and rehabilitation]. He is too much unlike the man in the street to permit his example to be useful for the purposes of deterrence. He is too far removed from normality to make us angry with him. But because he is sick rather than evil, society is cast as specially responsible for him and obligated to make him better.

A. GOLDSTEIN, *supra* note 28, at 15.

dards of conduct as others.⁵⁷ We also presume that his illness was brought about by circumstances beyond his control.⁵⁸ An actor who, without these essential capacities, causes harm to another will not diminish the moral standards of society if the individual is not held criminally responsible.⁵⁹ Isolating or punishing members of society for acts for which they were not individually responsible, or conversely, rewarding or excusing those who are justly held responsible would violate our collective sense of morality and bespeak hypocrisy.⁶⁰

Some mental "illnesses", in spite of being present at the time of an offense, will not undermine criminal responsibility.⁶¹ In some cases, this is a result of the definition of insanity,⁶² and in other cases, it is a result of a limitation on the insanity defense. The insanity defense will only be valid in those cases which the actor's incapacity was not self-induced or where the actor's incapacity was caused by circumstances beyond his control.⁶³ At the core of this policy is the notion that the capacity to reason is an inestimable attribute of human nature. An actor who chooses to deprive himself of the influences of reason so that basal impulses direct his behavior breaches a duty owed by him to society that warrant's condemnation.⁶⁴ When an actor causes his own incapacity and that incapacity influences his conduct, he will not be freed from responsibility.⁶⁵ Because the insanity defense serves to differenti-

57. See A. GOLDSTEIN, *supra* note 28, at 114; Moore, *supra* note 56, at 1149.

58. See *supra* note 41 and accompanying text.

59. See generally F. WINSLOW, *supra* note 28, at 67 (stating that an insane person cannot be deemed a responsible moral agent).

60. Morris, *supra* note 34, at 506-509 ("If an individual cannot exercise choice, he cannot be deterred, and it is a moral outrage to punish him."); see also MODEL PENAL CODE § 1.02 comment 2(c) (stating that one purpose of an effective penal code is to assure that conduct that is not morally reprehensible will not warrant criminal sanction).

61. Slovenko, *The Meaning of Mental Illness in Criminal Responsibility*, 5 J. LEGAL MED. 1 (1984).

62. See MODEL PENAL CODE § 4.01(c) (excluding antisocial conduct disorder from consideration under insanity).

63. See *supra* note 41 and accompanying text. Also, compare MODEL PENAL CODE § 2.08(4) (involuntary intoxication creates an affirmative defense if the cognitive or volitional prongs of the insanity defense are fulfilled) and MODEL PENAL CODE § 2.08(1)-(3),(5) (voluntary intoxication, that is, intoxication as a result of knowingly introducing substances into one's own body, is not a defense, nor a mental disease, nor can its presence negate recklessness on the part of a voluntarily intoxicated offender).

64. See, e.g., Jones v. State, 648 P.2d 1251 (Okla. Crim. App. 1982) (discussed *infra* notes 113-119 and accompanying text).

65. Robinson, *Causing the Conditions*, *supra* note 7, at 1-20. Robinson classifies the degrees of causation currently necessary to impact on one's defense as follows: (1) with-

ate between the blameworthy and those that cannot justly be blamed for their conduct, the actor who causes his own incapacity has no recourse but to blame himself for his condition, and society is entitled to condemn him for any harm done.⁶⁶ Because adults are presumed to be sane and possess the capacity to exercise free choice, to reason, to make moral choices and to control their own conduct, an actor who deprives himself of those capacities which influence his conduct will not be excused.⁶⁷

Consider one who is voluntarily intoxicated who blacks out while driving. If while incapacitated he were to hit a pedestrian, he could be held responsible for criminal offenses committed at two different times. His criminal liability could be based on either the precedent conduct, driving while intoxicated, or the subsequent conduct, reckless homicide. In either case, he may not intend harm while deciding to drive or while driving. Yet, in choos-

holding a defense upon any causal contribution; (2) withholding a defense upon a minimum culpability as to causing the defense conditions; (3) imposing reduced liability upon a minimum culpability as to causing the defense conditions; and (4) imposing a degree of liability corresponding to the level of culpability as to causing the defense conditions. *Id.* As a general principle, Robinson proposes that no degree of causation should serve as a bar for relying on a defense for the conduct constituting a defense, but as an alternative, liability should be based on "the actor's conduct and culpability at the time of causing the conditions of his defense . . ." *Id.* at 26-27. His proposal to make the precedent conduct (that conduct which precedes the conduct which constitutes an offense) an offense (based on the conduct and culpability at the time of causing his defense) is rejected in this Note, although the conceptual analysis of looking to the precedent conduct to determine the level of culpability is accepted.

66. See Bazelon, *Morality*, *supra* note 35, at 4.

67. Theoretically, this limitation on the insanity defense may be grounded on several rationales. Under a causal perspective, the actor who brings about his own disabling condition should not be allowed to rely on his incapacity to exculpate because he is the agent responsible for disabling himself. Mitchell, *Culpable Mental Disorder*, *supra* note 14, at 273-74. He has caused his own incapacity and is appropriately blamed for its presence as well as the resulting harm. Mitchell, *The Intoxicated Offender*, *supra* note 14, at 77-78. Under a social duty perspective, the actor has an obligation to society to utilize his ability to reason. If he renders himself without this capacity, he has breached his duty and is appropriately sanctioned. *Cf. infra* notes 95-149 and accompanying text (discussing the blameworthiness of voluntary intoxication and the presence of recklessness as the *mens rea* of a defendant in such a situation). Under a culpability perspective, the actor's conduct represents a manifestation of his disregard for social order, which reflects on the actor's immoral reasoning. Under a comparative culpability perspective, the actor who is incapacitated because of freely chosen conduct is more blameworthy than an actor who experiences the same incapacity because of circumstances beyond his control. See Robinson, *Imputed Criminal Liability*, 93 YALE L.J. 609, 660-63 (1984) [hereinafter Robinson, *Imputed Criminal Liability*]. Under a capacity perspective, the actor who utilizes reason to deprive himself of his ability to reason, cannot later point to his lack of capacity to excuse himself because he is presumed to have intended the necessary result of his decision to act irrationally.

ing to drive while intoxicated, he will have disregarded a substantial and unjustifiable risk of harm of which he was aware. This mental state will either be presumed with respect to driving or will be carried forward and imputed to the time of the homicide.⁶⁸ Examining the precedent conduct makes it possible to determine the actor's level of culpability.⁶⁹ If the actor was aware that driving while intoxicated created a substantial and unjustifiable risk of death or serious bodily harm, but he consciously disregarded that risk and brought about his own incapacity, his reckless mental state with respect to risking the harm done may be imputed to the subsequent offense.⁷⁰

In addition to the divergence over whether the precedent or subsequent conduct should constitute the *actus reus* of the offense, criminal law theory diverges over how to establish criminal responsibility. To more fully explore the significance of which conduct should be sanctioned⁷¹ and how criminal law doctrine deals with a mental state absent at the time of the subsequent offense,⁷² the following sections are presented with the goal of developing an analytical framework to be applied in Part II.

68. Even though driving while intoxicated is an offense which does not require the presence of intent, a *malum prohibitum* offense, it is considered to involve a danger to public safety. Under such circumstances, engaging in the conduct itself is sufficient evidence to give rise to culpability. See *Morissette v. United States*, 342 U.S. 246 (1952).

69. There are two points in time at which criminal responsibility may be imposed. The first (the precedent offense - driving while intoxicated) revolves around the risk taken, where a danger or probability of harm exists, while the second (the subsequent conduct - homicide) revolves around the actual harm done. See *infra* notes 73-149 and accompanying text.

70. *Commonwealth v. Welansky*, 316 Mass. 383, 55 N.E.2d 902 (1944). In drawing a distinction between gross negligence and recklessness, the court stated:

Usually . . . reckless conduct consists of an affirmative act . . . in disregard of probable harmful consequences to another. But where . . . there is a duty of care . . . reckless conduct may consist of intentional failure to take such care in disregard of the probable harmful consequences

To define . . . reckless conduct so as to distinguish it clearly from negligence or gross negligence is not easy To constitute . . . reckless conduct, as distinguished from mere negligence, grave danger to others must have been apparent and the defendant must have chosen to run the risk rather than alter his conduct so as to avoid the act or omission which caused the harm. If the grave danger was in fact realized by the defendant, his subsequent voluntary act or omission which caused the harm amounts to . . . reckless conduct, no matter whether the ordinary man would have realized the gravity of the danger or not.

Id. at 397-98, 55 N.E.2d at 909-10 (citations omitted).

71. See *infra* notes 85-94, 229-54 and accompanying text.

72. See *infra* notes 95-149, 243-60 and accompanying text.

B. Epilepsy and Intoxication: Inculpatory Exceptions to Exculpation

1. Epilepsy: Precedent and Subsequent Offenses.

The exception to exculpation in cases of self-induced incapacity has been applied to situations involving epilepsy. Epilepsy has been treated as a mental disease for the purposes of the insanity defense as well as the basis of an involuntary act defense.⁷³ Under the insanity test, an epileptic who commits a criminal act while having a seizure may show that he had a mental defect and that the defect caused the actor to lack substantial capacity to both appreciate the wrongfulness of his conduct and to conform his conduct to the requirements of the law. An epileptic who is aware of his propensity for having seizures but disregards that risk by failing to take medication to control them causes his own incapacity. He can thus be held responsible for an offense despite his ability to meet the criteria for insanity at the time of the act.⁷⁴ Responsibility may be imposed either by making the precedent conduct a criminal offense or by imputing the mental state behind the precedent conduct to the subsequent offense.

In *People v. Decina*,⁷⁵ the defendant had a history of epileptic seizures. He had been given medication to control them and had not taken the medication prior to driving his car. While driving, he had a seizure, lost control of his car and collided with four young schoolgirls. He then caromed through a metal lamppost and the brick wall of a grocery store.⁷⁶ The four children were killed. The defendant was charged with culpable negligence in the operation of an automobile with knowledge that he was subject to epileptic attacks.⁷⁷ The court examined his mental state prior to the

73. See, e.g., *People v. Grant*, 46 Ill App. 3d 125, 360 N.E.2d 809 (1977), *rev'd on other grounds*, 71 Ill.2d 551, 377 N.E.2d 4 (1978).

74. The noncompliant psychiatric offender has conceptually run a similar risk in deciding to discontinue medication that an epileptic runs in deciding to risk harm to others by not taking his medication. They each have an endogenous disorder that may be effectively controlled by medication. Noncompliance enhances the probability that the disorder will manifest itself. Moreover, by being noncompliant, the actor disregards the risk that the illness will recur and is left without cognitive or volitional capacity at the time harm occurs. Responsibility is justly determined in light of the risk taken in both cases, not by reference to the time the harm occurred, but with respect to the decision to run the risk. *Grant* appropriately examines the level of awareness the actor entertained at the time of taking the risk. *Id.* at 131-33, 360 N.E.2d at 815-16.

75. 2 N.Y.2d 133, 138 N.E.2d 799, 157 N.Y.S.2d 558 (1956).

76. *Id.* at 135-36, 138 N.E.2d at 800-01, 157 N.Y.S.2d at 560-61.

77. *Id.* at 138-39, 138 N.E.2d at 803, 157 N.Y.S.2d at 564.

deaths, noting that the defendant knew he was prone to epileptic seizures, that he knew that a car moving on the road out of control was a "highly dangerous instrumentality capable of unrestrained destruction" and that he assumed that risk by consciously choosing to drive by himself without taking his medication "in disregard of the consequences that he knew might follow . . ." ⁷⁸ The court found the defendant to be culpably negligent for taking the risk. ⁷⁹

In *People v. Grant*,⁸⁰ the defendant had been convicted of aggravated battery and obstructing a police officer. He had a history of psychomotor epilepsy⁸¹ and experienced a grand mal convulsive seizure after being taken into custody for the offense.⁸² The jury rejected the insanity defense, but because the trial court had not tendered an instruction on an automatism defense, the appellate court remanded the case. In an attempt to clarify the circumstances which might create liability for the defendant, the court stated, "the jury may, on remand, determine that the defendant [committed battery] while in a state of automatism, but that he nevertheless committed an offense for which he is criminally responsible if he had prior notice of his susceptibility to engage in violent involuntary conduct brought on by . . . conscious causal behavior."⁸³ In so doing, a jury would examine the precedent conduct in order to determine a mental state with respect to the subsequent harm done and would impute that *mens rea* to the subsequent offense. If the defendant was aware or should have been aware that he was prone to violent outbursts but disregarded that knowledge, he would be held responsible for aggravated battery.⁸⁴

These two cases support different approaches to criminal lia-

78. *Id.* at 140, 138 N.E.2d at 803-04, 157 N.Y.S.2d at 565.

79. *Id.*, 138 N.E.2d at 804, 157 N.Y.S.2d at 565. *See generally* State v. Gooze, 14 N.J. Super. 277, 286, 81 A.2d 811, 816 (Super. Ct. App. Div. 1951) (defendant with a history of blackouts from an endogenous disorder was held responsible for risking harm during an auto accident where "it was reasonably foreseeable that if he 'blacked out' or became dizzy without warning, its probable consequences might well be injury or death to others").

80. 46 Ill. App. 3d 125, 360 N.E.2d 809 (1977).

81. *Id.* at 127, 360 N.E.2d at 812. There is no discussion in the record as to whether his failure to take medication contributed to his conduct at the time of the offense.

82. *Id.* at 127, 360 N.E.2d at 812 (The defendant claimed to have experienced a psychomotor seizure at the time of the offense, but the court was skeptical of this claim.).

83. *Id.* at 131-32, 360 N.E.2d at 815.

84. *Id.* at 132, 360 N.E.2d at 816; *see also* Virgin Islands v. Smith, 278 F.2d 169 (3d Cir. 1960) (defendant who experienced a seizure while driving, killed two pedestrians and appealed his conviction for involuntary manslaughter).

bility. In *Decina*, the defendant had been charged with an offense that involved the precedent risk. In *Grant*, the defendant had been charged with an offense which involved the actual resulting harm. Each approach may serve the aims of maintaining social order and imparting a higher sense of lawfulness. The *Decina* approach may be less of a theoretical distortion to the concept of limiting criminal offenses to those which satisfy the *mens rea* requirement at the time of the *actus reus*, but the *Grant* approach is more desirable when harm does occur because a closer approximation of the actor's culpability may be established.

The desire to make the precedent conduct an offense derives from cases where two actors run the same risk,⁸⁵ but because of fortuity, only the one who causes harm will be punished.⁸⁶ The precedent conduct is believed to be equally blameworthy; therefore, the fortuitous occurrence of harm should not serve to differentiate risktakers for punishment purposes.⁸⁷ Yet, where no harm occurs in either case, punishing risktakers would only be justified if the magnitude of harm as well as the probability of harm occurring is very high. Where the probability of harm is so low that risks taken are rarely likely to result in harm to society, punishment to maintain social obedience may not support condemning the conduct.⁸⁸ For example, if an epileptic is taking antiseizure medication and the medication is effective in 99.5 percent of cases, the probability of harm resulting from driving is very low; yet, the magnitude of harm is the same. In such a case, can we punish the actor for risking a seizure while driving under these circumstances? While defying social authority may be viewed as sufficient grounds for imposing criminal liability for engaging in conduct that does not result in harm,⁸⁹ the argument does not seem to be applicable where the probability of harm is low.⁹⁰

Only when the epileptic discontinues his medication will the probability and the magnitude of harm become substantial and

85. A risk represents the possibility or probability of the occurrence of an event which may or may not occur. Risks may be long term or short term. A person may set in motion a chain of events that leads to the occurrence of the event. Cf. BLACK'S LAW DICTIONARY (5th ed. 1979) (defining risk as the danger or possibility of a loss).

86. See MODEL PENAL CODE § 211.2 comment 2.

87. *Id.*

88. This would also be true if the risk would only result in insubstantial harm.

89. See *Morrisette v. United States*, 342 U.S. 246 (1952).

90. Indeed the Model Penal Code would require that the risk be substantial and unjustifiable; for the risk to be substantial the conduct must place another in danger of death or serious bodily harm. MODEL PENAL CODE § 2.02(c).

unjustifiable. The probability of harm increases, and that harm should be apparent.⁹¹ Only in such circumstances can we hold the actor responsible for running a risk.⁹² This approach would make noncompliance with epileptic medication an offense in and of itself where the actor negligently disregards a substantial unjustifiable risk. In a broad sense, those who threaten substantial harm to others by disregarding risks do harm to society.⁹³ In such cases, for the benefit of society, the occurrence of such risks should be criminally sanctioned.

Defining an offense without reference to harm functions to prevent the occurrence of harm. Whether or not harm might have actually occurred is unimportant. Yet in each case above, punishment of the precedent offense will not distinguish between those who have caused greater or lesser harm. It will merely hold the actor responsible for disregarding the risk.

Where harm has occurred, fortuity will not justify withholding punishment for the harm done. The risk has been taken, and harm has been done. Punishing the actor for the harm serves the retributivist aim of exacting a debt owed and equalizing harm done to society.⁹⁴ The actor's *mens rea* with respect to the harm done can be established either at the time of the precedent or subsequent conduct, and he can be punished accordingly. The next section will explore different approaches to establishing *mens rea* for the subsequent harm.

2. Intoxication

As a general proposition, intoxication is not a defense to a criminal act.⁹⁵ Intoxication will only provide a defense to criminal conduct if the intoxication negates the presence of a mental state required as an element of the offense, is involuntarily induced or is pathological.⁹⁶ In the event that the intoxication results from

91. If the defendant in *Decina* were to again drive while not taking medication, it would be fair to say that his mental state would be at least reckless bringing him under the reckless endangerment provision of the Model Penal Code, regardless of whether harm occurred on that subsequent outing. *Id.* § 211.2.

92. In *Decina* and *Grant* both the probability and the magnitude of harm were high. See *supra* notes 75-77, 80-82 and accompanying text.

93. See MODEL PENAL CODE § 211.2 comment 1.

94. See *id.* § 211.2 comment 2.

95. *Id.* § 2.08(1).

96. *Id.* § 2.08(1)-(4); e.g., *Jones v. State*, 648 P.2d 1251, 1254 (Crim. App. Okla. 1982).

pathological drinking⁹⁷ or if it is not self-induced,⁹⁸ such that at the time of the offense, the actor lacks substantial capacity to either appreciate the wrongfulness of his conduct or to conform to the requirements of the law, the intoxication will provide an affirmative defense.⁹⁹ Further, if the effects of long-term substance abuse result in a permanent mental disease or defect, such as an organic brain syndrome, the syndrome would be considered a mental disease or defect under insanity.¹⁰⁰ In the case of a homicide offense which requires a *mens rea* of knowledge or purpose, intoxication may be available to negate the presence of such an intent, although at a minimum, recklessness will be found to exist.¹⁰¹ This may have the practical effect of reducing the degree of the offense from first degree murder to reckless homicide or manslaughter.¹⁰² When an offense requires recklessness, voluntary intoxication will not negate awareness of risks of which the actor would have been aware if he had not been intoxicated.¹⁰³ In other words, despite being unaware of risks due to being voluntarily intoxicated at the time of an offense, recklessness can be imputed to the actor, and he will be held responsible.¹⁰⁴

An offender with a drug-induced psychosis could fulfill the cognitive and volitional prongs of the insanity defense by establishing that he lacked substantial capacity to appreciate the

97. Pathological intoxication is "intoxication grossly excessive in degree, given the amount of the intoxicant, to which the actor does not know he is susceptible." MODEL PENAL CODE § 2.08(5)(c).

98. Intoxication "caused by substances which the actor [does not] knowingly introduce[] into his body, the tendency of which to cause intoxication he [does not] know[] or ought [not] know, [or if] he introduces them pursuant to medical advice or under such circumstances as would afford a defense to a charged crime." *Id.* § 2.08(5)(b).

99. *Id.* § 2.08(4).

100. See, e.g., *State v. Ostwald*, 180 Mont. 530, 591 P.2d 646 (1979).

101. MODEL PENAL CODE § 2.08(2). There is a distinction which some courts make with crimes of general versus specific intent. It is said that intoxication will never negate general intent but may negate specific intent. See *United States v. Burnim*, 576 F.2d 236 (9th Cir. 1978) (discussed *infra*, notes 122-26 and accompanying text); see also *Jones v. State*, 648 P.2d 1251, 1254 (Crim. App. Okla. 1982) (holding that voluntary intoxication will not constitute an insanity defense); *Robinson, Imputed Criminal Liability*, *supra* note 68 at 660-63 (discussing the effects of voluntary intoxication on criminal responsibility); *Robinson, Criminal Law Defenses: A Systematic Analysis*, 82 COLUM. L. REV. 199, 207 (1982) (discussing the theory behind withholding a defense in the case of self-induced intoxication); Annotation, *Effect of Voluntary Drug Intoxication upon Criminal Responsibility*, 73 A.L.R. 3d 98, § 6 (1976) (discussing the view that drug intoxication may be a complete or limited defense).

102. *Robinson, Causing the Conditions*, *supra* note 7, at 15.

103. MODEL PENAL CODE § 2.08(2).

104. *Robinson, Imputed Criminal Liability*, *supra* note 68, at 639-42, 660-63.

wrongfulness of his conduct or the capacity to conform his conduct to the requirements of the law.¹⁰⁵ Under the insanity defense, however, a psychosis that is the result of voluntary intoxication will not provide a defense.¹⁰⁶ This is so because the choice to become intoxicated which causes the incapacity is viewed as blameworthy.¹⁰⁷ The actor will be responsible for the resultant harm done with a *mens rea* - at a minimum of risking the resultant incapacity, and a maximum of having the purpose to do the resulting harm.

Theoretically, courts have several options when considering how to establish *mens rea* when it would otherwise be absent as a result of voluntary intoxication.¹⁰⁸ In some circumstances, the actor will be held criminally responsible for the subsequent conduct based solely on an inquiry of intent at the time of the subsequent offense.¹⁰⁹ In other circumstances, the effect of the incapacity on the actor's mental state at the time of the subsequent offense, regardless of severity, will not be considered.¹¹⁰ In still other cir-

105. See *United States v. Burnim*, 576 F.2d 236 (9th Cir. 1978).

106. See, e.g., *State v. Hall*, 214 N.W.2d 205, 207 (Iowa 1974).

107. See *Robinson, Imputed Criminal Liability*, *supra* note 67, at 639 n.106 ("[W]e punish a man for his very ignorance, if he is thought responsible for the ignorance . . . for the moving principle is in the man himself, since he has the powers of not getting drunk and his getting drunk was the cause of his ignorance.") (quoting ARISTOTLE, *ETHICA NICOMACHEA* 1113b (W. Ross trans. 1931)); see also, *Greider v. Duckworth*, 701 F.2d 1228 (7th Cir. 1983) (discussed *infra* notes 125-29 and accompanying text). This is analogous to deliberate ignorance, where in spite of not actually being aware, because such lack of awareness was "solely and entirely because of . . . [a] conscious purpose . . . to avoid learning the truth," *United States v. Jewell*, 532 F.2d 697 (9th Cir. 1976), the actor is imputed with the awareness of what he would have had had he not been deliberately ignorant. See, e.g., *id.* at 703-04 (holding that defendant who was deliberately ignorant of 110 pounds of marijuana in the trunk had "knowledge" of marijuana).

108. *Mitchell, The Intoxicated Offender*, *supra* note 14, at 77-78, suggested three options:

The simplest, fairest, and most honest course is to inquire directly into whether intoxication actually eliminated or compromised the required mental element of the offense charged The second avenue open is to deny, in whole or in part, a mitigating role to intoxication even if *mens rea* happens to be absent because of voluntary drug use A third choice is to find drug taking to be criminally negligent or reckless or, what amounts to the same thing, to create a separate offense of being "drunk and dangerous."

In *Robinson, Causing The Conditions*, *supra* note 7, at 50-63, the author proposed a "causing-one's-defense" doctrine. This doctrine uses the mental state at the time of the precedent conduct to determine if defendant acted with the culpability required by the offense charged. *Id.*

109. See *infra* notes 113-19 and accompanying text.

110. See *infra* notes 120-24 and accompanying text. Yet, there are other cases where prior voluntary conduct on the part of the defendant will not bar exculpation on the

cumstances, the mental state associated with the precedent conduct will be imputed as the actor's state of mind at the time of the subsequent offense.¹¹¹ A final approach would be to allow the absence of a mental state at the time of the offense to serve as a defense but to hold the actor responsible for risking the harm and establishing his mental state to be that in existence at the time the risk was taken.¹¹² The following cases illustrate judicial application of these principles to defendants who were in a psychotic state at the time of the subsequent offense as a result of voluntary intoxication but were found responsible for the subsequent harm done.

In *Jones v. State*,¹¹³ the defendant had been convicted of first

grounds of insanity. *See, e.g., State v. Maik*, 60 N.J. 203, 287 A.2d 715 (1972) (Defendant had taken lysergic acid diethylamide (LSD) and thus contributed to causing the onset of schizophrenia. However, the fact that the schizophrenia persisted after the effects of LSD had ceased led the court to conclude that in spite of the defendant having contributed to causing the onset of his illness, his illness was genuine and was a mental disease the defendant would have experienced regardless of having taken LSD.), *overruled in part, State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975) (The court held that the New Jersey statutory standards for the commitment of persons who, by reason of insanity were either acquitted, or against whom charges were dropped had been unconstitutionally construed in *State v. Maik*. The plaintiffs in *Maik* did not challenge the constitutionality of the statute).

111. *See infra* notes 125-29 and accompanying text. Imputing a state of mind from the precedent act to the subsequent offense and holding the actor responsible for the subsequent offense based on the nature of conduct engaged in prior to and at the time of the offense is normally used to impute liability for an offense where the mental elements of the offense have not been established. For a discussion of "imputed liability" in the felony murder context, see Robinson, *Imputed Criminal Liability*, *supra* note 67, at 623-26. Where the actor engages in an armed robbery and has no intent to kill, but a bystander is killed during the commission of the felony, the actor will be held responsible for murder, imputing an intent to kill from engaging in an inherently dangerous felony. *Id.* Theoretically, imputing a state of mind under these circumstances is inconsistent with the notion that criminal liability is appropriate only when all offense elements have been established, but has been justified by policy concerns that the risk of harm to others associated with engaging in armed robbery are so high and so likely to occur, that we may assume that an actor who chooses to engage in the crime must intend the natural and probable consequences of his conduct. *Id.* at 623-36; *see also Perkins v. Grammer*, 664 F. Supp. 1280, 1284 (D. Neb. 1987) (Nebraska's felony-murder statute is constitutional), *aff'd*, 838 F.2d 294 (8th Cir. 1988), *cert. denied*, 108 S.Ct. 2876 (1988); *Victory v. Bombard*, 432 F. Supp. 1240, 1243-44 (S.D.N.Y. 1977) (The policy is to deter felon's from acting in a manner that increases the likelihood of violence.), *rev'd on other grounds*, 570 F.2d 66 (2d Cir. 1978), *habeas corpus proceeding sub nom. Victory v. Lefeure*, 709 F. Supp. 496 (S.D.N.Y. 1989); *State v. Canola*, 73 N.J. 206, 374 A.2d 20 (1977) (felony-murder statutes are "restricted to persons 'so killing,' i.e., felon or his agents not third persons).

112. Robinson, *Causing The Conditions*, *supra* note 7, at 50-63 (proposing the precedent conduct as an offense); *see also* MODEL PENAL CODE § 211.2 ("A person commits a misdemeanor if he recklessly engages in conduct" which places another in danger).

113. 648 P.2d 1251 (Okla. Crim. App. 1982), *cert. denied sub nom., Jones v. Oklahoma*, 459 U.S. 1155 (1983), *later proceeding Jones v. State*, 704 P.2d 1138 (Okla.

degree murder and was sentenced to death. He had committed the murder while under the influence of alcohol and medication,¹¹⁴ and he offered testimony that he suffered from a toxic psychosis at the time of the offense.¹¹⁵ In reviewing the law applicable to one who is voluntarily intoxicated, the court stated:

There is, in truth, no injustice in holding a person responsible for his acts committed in a state of voluntary intoxication. It is a duty which every one owes to his fellow men, and to society, . . . to preserve, as far as lies within his power, the inestimable gift of reason [I]f, by a voluntary act, he temporarily casts off the restraints of reason and conscience, no wrong is done him if he is considered answerable for any injury which, in that state, he may do to others or society,¹¹⁶

After rejecting an insanity plea,¹¹⁷ the court considered whether his intoxication had negated an element of the offense.¹¹⁸ By examining the circumstances surrounding the offense, the court reached the conclusion that his intoxication had not negated intent at the time of the offense.¹¹⁹

In *United States v. Burnim*,¹²⁰ the defendant had been convicted for unarmed bank robbery.¹²¹ The district court found that the defendant suffered from an organic brain defect, and that he

Crim. App. 1985) (denying application for post-conviction relief).

114. The defendant had been taking Ativan. *Id.* at 1256. Ativan is an anti-anxiety agent used in the treatment of anxiety disorders. PHYSICIANS DESK REFERENCE 2125 (38th ed. 1984).

115. 648 P.2d at 1256.

116. *Id.* at 1255 (quoting *People v. Lim Dum Dong*, 26 Cal. App. 2d 135, 139, 78 P.2d 1026, 1028 (1938)).

117. At the outset, the *Jones* court considered the defendant's reliance on the insanity defense as misplaced because he had no mental disease separate from or as a result of his intoxication. The court stated that temporary insanity resulting from voluntary intoxication is not a mental disease within the purview of insanity. *Id.* at 1254. The court went on to review the sufficiency of evidence supporting defendant's insanity defense, but found that "the [defendant] did not introduce sufficient evidence to raise a reasonable doubt as to whether he was suffering from a mental disorder due to prolonged alcohol or drug use." *Id.* at 1255.

118. *Id.* at 1255 ("[I]ntoxication would not excuse or mitigate crime unless accused had been so intoxicated that his mental powers had been overcome and it had therefore been impossible for him to form criminal intent.") (quoting *Miller v. State*, 567 P.2d 105, 109 (Okla. Crim. App. 1977)).

119. *Id.* at 1257. The court relied on evidence offered by lay witnesses as well as comments made by the defendant to support the lower court's ruling that the defendant entertained the intent necessary to commit murder. *Id.* at 1256-57.

120. 576 F.2d 236 (9th Cir. 1978).

121. *Id.* at 237. The court noted that unarmed bank robbery is a general intent crime to which voluntary intoxication is no defense. *Id.*

met the cognitive and volitional prongs of the insanity defense,¹²² but because the lack of capacity arose as a result of voluntary intoxication in combination with the brain defect, the insanity defense was rejected.¹²³ The court rejected the defense because "Burnim's 'insanity' was the product of his voluntary intoxication, in the absence of which he would not have been insane" and that the organic brain defect alone would not have given rise to an insanity defense.¹²⁴ The court then excluded all effects of the intoxication on the defendant's conduct at the time of the offense and affirmed his conviction.

In *Greider v. Duckworth*,¹²⁵ the defendant was in a state of psychosis at the time of the homicides as a result of voluntary ingestion of heroin and valium.¹²⁶ He challenged his murder conviction on the grounds that "the state failed to present evidence sufficient to rebut his defense that he was insane at the time the crime was committed."¹²⁷ Unlike the court in *Jones*, the *Greider* court did not examine whether intent was negated by intoxication at the time of the offense but imposed criminal liability on the theory of imputed liability or transferred intent.¹²⁸ The court "applied the common law view whereby when one voluntarily be-

122. *Id.*

123. The court concluded that, but for the defendant's intoxication, he would not have been insane at the time of the offense. *Id.*

124. *Id.* at 237-238. The court relied on *Kane v. United States*, 399 F.2d 730 (9th Cir. 1968), *cert. denied*, 393 U.S. 1057 (1969), where the defendant also suffered from an organic brain defect which exposed him to 'pathological intoxication.' In *Kane*, the defendant knew that when he drank he would act violently and be prone to blackouts. The court rejected his insanity defense, stating:

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.

Kane, 399 F.2d at 736 (emphasis added).

125. 701 F.2d 1228 (7th Cir. 1983).

126. *Id.* at 1231.

127. *Id.* at 1231. The court pointed out the general common law rule that, "voluntary intoxication [is] not a defense in a criminal proceeding. In order for intoxication to relieve a defendant from responsibility, the crime charged must have involved specific intent, and the defendant must have been so intoxicated as to be incapable of entertaining the required specific intent." *Id.* at 1232 (citations omitted). The court also noted that "[c]ommentators have criticized this formulation of the rule suggesting that as framed the rule renders the defense illusory, because if literally applied by the trier of fact, one would have to be unconscious before he could avail himself of the defense." *Id.* at 1233 n.6 (citing *Carter v. State*, 408 N.E.2d 790, 802 (Ind. Ct. App. 1980)).

128. *Id.* at 1233.

comes intoxicated, guilt is attached to the intoxication itself, and is then transferred to the criminal act, supplying the required culpability" and affirmed his conviction.¹²⁹

In each case, the court sought to impose criminal liability for the harm done, rather than on the risk taken. Each court ultimately reached the same result - conviction. The principle that drove the courts was that a voluntarily induced incapacity cannot excuse harmful actions. Regardless of the theory espoused by the defendant, in the context of an insanity defense, the only incapacities that will form the basis of an insanity defense are those that are caused by factors beyond the control of the actor. Because of the strong desire to punish an actor for the harm done and the belief that any harm done while voluntarily incapacitated should be punished, a method for imposing liability should consistently reflect both the actor's culpability and the magnitude of the harm done.

This Note takes the position that transferring *mens rea* from the precedent to the subsequent conduct is the most effective approach.¹³⁰ The difficulty associated with finding *mens rea* associated with the subsequent conduct without looking back in time to the freely-chosen caused conduct is that at some levels of incapacity, no *mens rea* will be found with respect to the subsequent act.¹³¹ In such cases, the self-induced incapacity will excuse. An acquittal under such circumstances would not serve to differentiate between culpable and nonculpable conduct nor serve the notions of criminal responsibility.

Alternatively presuming *mens rea* to accompany the subsequent offense would not truly reflect the state of mind of the actor. This may be an alternative if no other means for differentiating between culpable offenders were available.¹³² Yet this is not the case where the actor has caused his own incapacity.

If the actor causes his own incapacity, we can determine

129. *Id.* (The lower court presumed that the defendant had intended the natural and probable consequences of his acts. *Greider v. State*, 270 Ind. 281, 284, 385 N.E.2d 424, 426 (1979)).

130. See *infra* notes 140-48 & 229-37 and accompanying text; see also Robinson, *Imputed Criminal Liability*, *supra* note 67, at 660-63 (The causal theory of imputed liability states that the actor is criminally liable for offenses arising from his voluntary intoxication.).

131. See, e.g., *Shell v. State*, 307 Md. 46, 512 A.2d 358 (1986) (The court found that the defendant's voluntary intoxication was severe enough to negate intent and reversed defendant's conviction for use of a handgun to commit a violent felony.).

132. See Robinson, *Imputed Criminal Liability*, *supra* note 67, at 619-21.

what his mental state was when the incapacity was induced.¹³³ We may determine the level of awareness the actor had with respect to the risks; the level of voluntariness with respect to disregarding the risks; whether any justification existed for disregarding the risk, and consequently, the degree of culpability.¹³⁴

While it has been argued that it is theoretically unsound to impute *mens rea* to an intoxicated offender and that it would be simpler to factually inquire into the effects of intoxication on mental state at the time of the offense,¹³⁵ in the broader context of identifying culpable offenders it would be more effective to examine the *mens rea* associated with the precedent acts which cause a subsequent incapacity. Where the actor has culpably caused the absence of the mental state with respect to the subsequent conduct, imputing the mental state associated with disregarding the precedent risk to the subsequent offense would best identify those who deserve punishment.¹³⁶ For example, if the actor intended to kill another and purposefully became intoxicated to create a defense, it would be appropriate to hold the actor criminally responsible for first degree murder.¹³⁷ If he knew that becoming intoxicated could result in the death or serious bodily harm to another, then it would be proper to hold him responsible for second degree murder.¹³⁸ If he had been aware that a substantial and unjustifiable risk of harm existed and he chose to disregard those risks and become intoxicated, he would be appropri-

133. Robinson, *Causing the Conditions*, *supra* note 7, at 50-51.

134. *Id.* 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 [sic] punish him for causing the ultimate justified or excused conduct. His punishment, however, is properly based on his initial conduct of causing the defense conditions with his accompanying scheming intention, not on the justified or excused conduct that he subsequently performs.

Id. Robinson argues that the actor should be allowed to rely on his incapacity to excuse the subsequent offense, and should be held responsible for the precedent conduct of causing his incapacity on the ground that this more accurately reflects the culpability of the actor. This Note views the rationale for looking to the prior conduct to determine culpability as sound, but rejects allowing the incapacity to excuse the subsequent conduct.

135. Mitchell, *The Intoxicated Offender*, *supra* note 14, at 77-78. On the other hand, simply denying the effects of intoxication and imposing liability by means of a but for test seems the theoretically least desirable approach. *Id.*; Robinson, *Imputed Criminal Liability*, *supra* note 68, at 160-61.

136. Robinson, *Causing The Conditions*, *supra* note 7, at 30-36.

137. *Id.* at 35-36.

138. *See id.*

ately held responsible for manslaughter.¹³⁹

Additionally, there are sound policy reasons for imputing liability.¹⁴⁰ First, the actor has caused his own incapacity.¹⁴¹ In and of itself, this is a culpable act. He must ultimately bear the burden of the foreseeable consequences that follow because his choice to cause his incapacity was made under circumstances within his control. Although offenses normally limit an inquiry of mental state to the time of the offense, the purpose of having criminal offenses is to punish blameworthy conduct as well as to prevent harm from occurring. If we allowed an intoxicated offender to escape liability because he was so intoxicated at the time of an offense that no intent was possible, blameworthy conduct would often go unpunished.¹⁴² There would be no legitimate purpose served in exculpating the intoxicated offender, other than steadfastly adhering to the criteria of an offense definition.¹⁴³ Without inquiring into the antecedent conduct that created the disability, one would have an offense that served its definition rather than the aims of criminal justice.¹⁴⁴ Second, the reasoning behind exculpating criminal conduct is that the actor cannot be blamed for

139. *See id.*

140. *See* Robinson, *Imputed Criminal Liability*, *supra* note 67, at 619-622. Robinson considers four theories - causal, equivalency, evidentiary and nonculpability - which offer justifications for imputing liability. Robinson suggests that in situations involving involuntary intoxication, felony murder, complicity, vicarious liability, strict liability, status and possession offenses, and omissions, imputing either an objective element or a state of mind is most convincing when supported by a causal theory. *Id.* A causal theory would justify imputing liability because the actor is "causally responsible for the commission of an objective element by another or for the absence of a required state of mind in himself or another." *Id.* at 620. An equivalency theory would justify imputing liability on the grounds that "the actor is as culpable as one who satisfies the element." *Id.* An evidentiary theory would support imputing an element on the grounds that it would be an unfair burden on the prosecution to require a showing of that element. *Id.* A nonculpability theory would rest imputing liability on protecting social interests. *Id.* at 620-21.

141. *Id.*

142. *See* MODEL PENAL CODE § 2.08 comment 1 ("Becoming so drunk as to destroy temporarily the actors powers of perception and of judgment is conduct which plainly has no affirmative social value to counterbalance the potential danger . . . [And there are] impressive difficulties posed in litigating the foresight of any particular actor at the time he imbibes. . .").

143. Sellers, *supra* note 31, at 264. Sellers argues that:

The premise on which such 'logic' is based betrays a highly formalistic approach since the assumption is that the definition is necessarily complete. Definitions, by their nature, deal with the paradigm case and not with all the penumbral situations which must be resolved, albeit with due regard for the policy implicit in the basic case.

144. *Id.* at 247-48, 264.

either his incapacity or the harm done.¹⁴⁵ Where the incapacity is brought about by conscious causal conduct, this reasoning no longer follows. If blameworthiness exists in causing the incapacity, the presence of the incapacity at the time of the offense cannot diminish blameworthiness for the harm done.¹⁴⁶ Third, imputing liability will allow a court to examine the offender's mental state prior to the offense and impute the *mens rea* to the subsequent offense that corresponds with the harm done. It then becomes possible to differentiate between culpable and nonculpable conduct.¹⁴⁷ If the actor intended the harm, was aware of the harm, foresaw or should have foreseen the harm, the *mens rea* at the time of the precedent conduct serves as the most accurate indicia of the actor's culpability with respect to the harm done. Finally, under a deterrent rationale, actors will not be allowed to induce an incapacity in order to escape criminal responsibility. If *mens rea* were not imputed, a 'grand schemer' could induce his own incapacity, render himself incapable of entertaining an intent at the time of the offense and escape punishment.¹⁴⁸

In sum, the criminal law assumes that people are sane and responsible for their conduct. Sanity and responsibility embody the notions of free choice, the capacity to reason, the capacity to make moral choices, the capacity to control conduct and the capacity to conform conduct to individual will. By having an insanity defense, we acknowledge that mental illness can deprive an individual of these capacities, ultimately infringing upon his ability to exercise free choice and rendering him an agent of his illness. Exculpation by insanity, then, serves to acknowledge the frailness of the human condition as well as to further our social morality and societal aims of imposing punishment only where responsibility lies. However, if the actor causes his own incapacity and is suffering from that incapacity at the time of the subsequent offense, he is appropriately held responsible for the harm done.

145. See, e.g., *United States v. Burnim*, 576 F.2d 236, 238 (9th Cir. 1978) (The court upheld the district court's findings, noting that the mental disability "must have been brought about by circumstances beyond the control of the actor.")

146. This roughly corresponds to what Robinson calls an equivalency theory. See Robinson, *Imputed Criminal Liability*, *supra* note 67, at 619-20, 660; see also Sellers, *supra* note 31, at 264-65 (concluding that because imposing criminal liability where the offender caused his or her own incapacity despite the lack of *mens rea* at the time of the act, is a just result, *mens rea* is not always the most vital element of an offense).

147. Robinson, *Causing Conditions*, *supra* note 7, at 35-36.

148. *Id.* at 31 n.114.

This may be accomplished by imputing the actor's mental state from the time the incapacity arose and the risk was taken to the conduct constituting the subsequent offense.¹⁴⁹

C. Noncompliance and Mental Illness

The threshold requirement of the insanity defense, the presence of a mental disease or defect, can be satisfied by showing that, at the time of the offense, the actor suffered from a mental illness.¹⁵⁰ Schizophrenia,¹⁵¹ a psychotic mental disorder, has frequently been used to excuse conduct otherwise constituting an offense.¹⁵² The definition of schizophrenia, its causes, symptoms and cures have varied throughout history.¹⁵³ It was not until the eight-

149. Robinson, *Causing the Conditions*, *supra* note 7, at 33; see *supra* note 140.

150. *People v. Ramsey*, 422 Mich. 500, 513-14, 375 N.W.2d 297, 302 (1985) ("Insanity by definition is an extreme of mental illness. When a person's mental illness reaches that extreme, the law provides that criminal responsibility does not attach. To put it alternatively, the [insanity defense] statutes provide that all insane people are mentally ill but not all mentally ill people are insane."); see also, Morris, *The Criminal Responsibility of the Mentally Ill*, 33 SYRACUSE L. REV. 477, 502 (1982) (all theories and rules supporting insanity pleas require a threshold finding of mental illness and a causal relationship between that illness and the conduct in question).

151. See Appendix A of this Note [hereinafter Appendix A] for the criteria for chronic paranoid schizophrenia listed in AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 194-197 (3d ed. rev. 1987) [hereinafter DSM-III-R].

152. Most frequently in the context of a criminal trial where the issue of an insanity defense is raised, the defendant is likely to be suffering from schizophrenia. In fact a recent study estimated that as many as 80.5 percent of insanity cases are diagnosed as schizophrenic. Steadman, Rosenstein, MacAskill, & Manderscheid, *A Profile of Mentally Disordered Offenders Admitted to Inpatient Psychiatric Services in the United States*, 12 LAW & HUMAN BEHAV. 91, 97 (1988); see also Bogenberger, Pasewark, Gudeman, & Beiber, *Follow-Up Insanity Acquittes in Hawaii*, 10 INT'L J. L. & PSYCHIATRY 283, 287-88 (1987) (schizophrenia was the dominant psychotic disorder diagnosed among "not guilty by reason of insanity" acquittes in Hawaii); Pogrebin, Regoli, & Perry, *Not Guilty by Reason of Insanity: A Research Note*, 8 INT'L J. L. & PSYCHIATRY 237 (1986). Schizophrenia is not the only disorder that meets the requirements for an insanity defense. Other psychotic disorders include: psychotic mood disorder, brief reactive psychosis, schizophreniform disorder, atypical psychosis, schizo-affective disorder, delusional disorder, organic hallucinosis, and organic delusional disorder. DSM-III-R, *supra* note 151, at 187-211. However, schizophrenia will be discussed to the exclusion of other diagnoses hereinafter. For a discussion of the legal significance of other mental disorders, see Slovenko, *supra* note 59, at 15-59.

153. Recorded symptoms of mental illness date back to biblical times, for example: Nebuchadnezzar, King of Babylon from 605-562 B.C., is considered to have suffered from lycanthropy - looking and behaving like a wild animal. His condition is mentioned in the Bible in the Book of Daniel: "And he was driven from men and did eat grass as oxen and his body was wet with dew of heaven till his hairs were grown like eagles' feathers and his nails like birds' claws."

eenth century that mental illness was recognized as a disorder of moral reason,¹⁵⁴ and widespread treatment with medication first began in the late 1950's.¹⁵⁵

Schizophrenia is one of several psychotic disorders which is commonly manifested as a disorder of cognition, speech, perception and volition.¹⁵⁶ Schizophrenia often first manifests itself in

J. CUTTING, *THE PSYCHOLOGY OF SCHIZOPHRENIA* 1 (1985). The causes of schizophrenic disorders have long been debated. For a thorough, but brief summary of theories regarding the etiology of schizophrenia, see W. SAHAKIAN, *PSYCHOPATHOLOGY TODAY* 110-25 (3d ed. 1986). See also K. BERNHIEM & R. LEWINE, *SCHIZOPHRENIA SYMPTOMS, CAUSES, TREATMENTS* 68-123 (1979) (discussing the causes of schizophrenia).

154. During the 1800's psychological treatment of the mentally ill took the form of treating moral causes:

If, for example, a patient believed that he had no head, he would be made to wear a heavy leaden cap until he capitulated. If he believed that there was a snake in his stomach he was given an emetic and a snake surreptitiously introduced into the vomit. [Other forms of therapy included] submersion in a tub of live eels, being made to walk across a flimsy bridge and being left to float in a leaky boat.

J. CUTTING, *supra* note 153, at 21; see R. WARNER, *supra* note 1, at 101-127.

155. Following the introduction of phenothiazines into the United States in the late 1950's, massive numbers of chronically ill psychiatric patients were released from state insane asylums, resulting in a 75 percent (approximately 420,000 patients) reduction in state mental hospital resident populations between 1955 and 1980. Morrissey & Goldman, *Cycles of Reform in the Care of the Chronically Mentally Ill*, 35 *HOSP. & COMMUNITY PSYCHIATRY* 785 (1984). Since that time, many of the mental health facilities that served as warehouses for the insane have closed down. Following deinstitutionalization, treatment for many of the mentally ill involves numerous hospital stays to achieve "stabilization" with many patients suffering periodic relapses, separated by periods of stability. C. KEISLER & A. SIBULKIN, *supra* note 1, at 188. For other psychiatric patients, the criminal justice system is a second home. R. WARNER, *supra* note 1, at 174-76; Bogenberger, Pasewark, Gudeman & Beiber, *Follow-Up Insanity Acquittees in Hawaii*, *supra* note 152 (discussing high recidivism among "not guilty by reason of insanity" acquittees); Weller & Weller, *Crime and Mental Illness*, 28 *MED. SCI. L.* 38 (1988). All too frequently, criminal conduct occurs as a result of the lack of support and community health services. R. WARNER, *supra* note 1, 174-77; see also, Caton, Goldstein, Serrano & Bender, *The Impact of Discharge Planning on Chronic Schizophrenic Patients*, 35 *HOSP. & COMMUNITY PSYCHIATRY* 255 (1984) (stressing the importance of aftercare in the prevention of relapse); N. BERAN & B. TOOMEY, *MENTALLY ILL OFFENDERS AND THE CRIMINAL JUSTICE SYSTEM: ISSUES IN FORENSIC SERVICES* (1979) (historical review of mental health services for offenders).

156. DSM-III-R, *supra* note 151, at 187-98; see also K. BERNHIEM & R. LEWINE, *supra* note 153 (fully describing the phenomenon of schizophrenia, its effects on the individual and the lives of those in intimate contact with him); M. HARROW, & D. QUINLAN, *DISORDERED THINKING AND SCHIZOPHRENIC PSYCHOPATHOLOGY* (1985) (reviewing major theories of disordered thinking and describing a series of empirical studies of schizophrenias and other disturbed patient populations); J.S. KASANIN, *LANGUAGE AND THOUGHT IN SCHIZOPHRENIA* (1944) (a collection of essays developing theoretical explanations of language and communication problems of schizophrenics); S. SCHWARTZ, *LANGUAGE AND COGNITION IN SCHIZOPHRENIA* (1978) (collection of chapters written by leading figures in the field of schizophrenic research, discussing recent developments in the

late adolescence. The onset of symptoms in the first stages of the illness, or the prodromal phase, usually takes the form of social withdrawal, impairment in role functioning, odd behavior, impairment in personal hygiene, odd beliefs, unusual perceptual experiences, and loss of will.¹⁵⁷ Symptoms gradually worsen during this stage and subsequently develop into an active phase of positive symptoms such as delusions, hallucinations and formal thought disorder.¹⁵⁸ It is usually at this stage of illness that treatment is necessary.

Antipsychotic medication may be administered in one of two ways: either the treating psychiatrist will administer a depot injection which is a time-released dose of medication effective for a period between fourteen and thirty days or the patient will be responsible for self-administration of tablets on a daily basis.¹⁵⁹ While the medication does not have the effect of eliminating the underlying disorder, it does help alleviate or may even eliminate the presence of the symptoms.¹⁶⁰ Once active symptoms develop, they generally wax and wane with periods of remission, sometimes without recurrence.¹⁶¹ Once treated, the active symptoms can be effectively controlled.¹⁶²

It is often the case that once released from a psychiatric care facility, the schizophrenic patient will discontinue medication, progressively deteriorate and within a matter of months be rehospital-

study of schizophrenic language and various aspects of schizophrenic cognition); L.J. CHAPMAN & J.P. CHAPMAN, *DISORDERED THOUGHT IN SCHIZOPHRENIA* (1973) (presents the leading theories of schizophrenia thought disorder and the evidence for each).

157. DSM-III-R, *supra* note 151, at 194-95.

158. M. HARROW & D. QUINLAN, *supra* note 156, at 11 (positive symptoms are "floridly symptomatic behavior[s], or unusual or bizarre thoughts"; negative symptoms are "the absence of normal functioning, or deficit state or defect state").

159. K. BERNHIEM & R. LEWINE, *supra* note 155, at 126; Johnson, *supra* note 3, at 13-14 (contrasts and discusses the advantages of depot and oral administration).

160. K. BERNHIEM & R. LEWINE, *supra* note 155, at 127. It is important to note that the treatments available for schizophrenia are neither curative nor preventative, but are ameliorative. Although these treatments diminish the severity of symptomatology and the functional impairment associated with the disorder, they do not in any way represent a "cure" for the underlying illness. Individuals who are prescribed antipsychotic medication for chronic schizophrenia, for the most part, will be required to take the medication in smaller or greater amounts for the balance of their lifetime to control their symptoms. Even those whose positive symptoms are effectively controlled with medication may experience negative symptoms as well as side effects. *See generally* Johnson, *supra* note 3, at 13 (maintenance therapy, including depot injections have proven successful in maintaining schizophrenic patients).

161. K. BERNHIEM & R. LEWINE, *supra* note 155, at 185.

162. *Id.* at 126-128.

ized, restabilized and redischarged.¹⁶³ It is not infrequent that the schizophrenic comes in contact with law enforcement officials who effectuate this revolving-door syndrome.¹⁶⁴

The broad criteria for the disorder, the various potential causes and idiosyncratic variability to treatment result in a range of functional ability and prognosis.¹⁶⁵ The problem of noncompliance with treatment is enormous¹⁶⁶ and may be more pronounced with psychiatric patients as a group than with other patients.¹⁶⁷ Noncompliance occurs when patients do not take their medication as prescribed, so-called medication errors, or when patients choose to discontinue medication against the advice of their physician.¹⁶⁸ A number of factors may contribute to the phenomenon of non-compliance. These include: "the illness - its quality and severity; the patient - how he perceives the illness and the treatment; the physician - his ability in negotiating an alliance; and the qualities of the setting and the regimen prescribed."¹⁶⁹ Although a number

163. *E.g.*, R. WARNER, *supra* note 1, at 258.

164. *Id.* at 174-78. In an interesting study, researchers examined the correlation between numbers of residence in psychiatric hospitals and prison populations in England and Wales over a 35 year period. Their results were striking. The research demonstrated the strong inverse relationship between these two variables and suggests that emptying state run psychiatric hospital beds has resulted in both increased overall crime rates and increased criminal convictions. Weller & Weller, *Crime and Mental Illness*, *supra* note 155.

165. *See generally*, K. BERNHIEM & R. LEWINE, *supra* note 153, at 185-208 (examines the timing and development of psychosis as well as providing examples of cases with good and poor outcomes); R. WARNER, *supra* note 1, at 16 (stresses such as work, family and environment may affect patient's recovery).

166. *See* Sackett & Snow, *supra* note 2 (compliance with long term medication regimens is approximately 50 percent); Boczkowski, Zeichner & DeSanto, *Neuroleptic Compliance Among Chronic Schizophrenic Outpatients: An Intervention Outcome Report*, 53 J. CONSULT. & CLIN. PSYCHOLOGY 666 (1985) (A study of thirty-six male chronic schizophrenic patients revealed that behavioral intervention may be more effective than psychoeducational intervention in curing the high noncompliance rate of schizophrenic patients.); Johnson, *supra* note 3, at 16 (studies conducted showed a high correlation between drug discontinuance and patient relapses).

167. *See* Sackett & Snow, *supra* note 2.

168. Gordis, *Conceptual and Methodological Problems in Measuring Patient Compliance*, in COMPLIANCE IN HEALTH CARE, *supra* note 2, at 23. Gordis points out the importance of "distinguish[ing] between noncompliance and medication errors. In the case of medication errors, the patient's intent is to comply but . . . circumstances may have confused him so that he does not or cannot follow the instructions. On the other hand, noncompliance implies an intent not to follow instructions . . ."

169. Waller & Altshuler, *supra* note 5, at 490; *see also* Haynes, *The Determinants of Compliance*, in COMPLIANCE IN HEALTH CARE, *supra* note 2, at 5, 49-109 ("Compliance is one of the least understood yet most guessed about topics in health care."); Boczkowski, Zeichner & DeSanto, *supra* note 166 (study showed high noncompliance rate among outpatient schizophrenics); Haynes, *A Critical Review of the "Determinants" of*

of theories have been advanced to explain the phenomenon, each patient will generally have his or her own reason for choosing not to comply with treatment.¹⁷⁰ In schizophrenics, relapse is often attributable to noncompliance with treatment.¹⁷¹ Noncompliance-induced relapse is often the precipitant of criminal acts of the mentally ill.¹⁷² A psychiatrist who addressed whether a schizophrenic has the capacity to act responsibly with respect to treatment, stated:

[I] cannot accept the view that these patients are untreatable and socially irredeemable - that is, until every innovative treatment modality has been explored and discarded as ineffective [C]hronic schizophrenics, no matter how crazy they may seem, are essentially responsible for their actions and can muster up the necessary will power to act sanely and decently if they should choose, or be made to choose, to do so Without regarding patients as responsible for their behaviors, we would be relegating them to a subhuman, even animal status where behavior is presumed to be determined more by instinct and drive level than by volition. For [if all behavior were] driven by forces beyond their control, their prognosis must be [viewed as] bleak It is rather paradoxical and contradictory that many

Patient Compliance with Therapeutic Regimens, in COMPLIANCE WITH THERAPEUTIC REGIMENS (D. Sackett & R. Haynes eds. 1976) (patient noncompliance is the result of many factors which makes alteration of behavior to favor compliance a more difficult task); Johnson, *supra* note 3, at 14 ("Problems of compliance are complex and depend on many factors, involving not only the patient but also his family's attitudes . . . the success of doctor-patient communication . . . and qualities of the treating staff . . . [making the problem of] noncompliance with oral medication extremely difficult to anticipate or prevent."); Van Putten, *Drug Refusal in Schizophrenia and the Wish to be Crazy*, 33 ARCH. GEN. PSYCHIATRY 1443 (1976) (study revealed that high noncompliance among schizophrenics may be the result of preferring a "florid psychosis to a drug-induced relative normality"); Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?* 31 ARCH. GEN. PSYCHIATRY 67 (1974) (reluctance among schizophrenics to take their medication was attributed to the extra-pyramidal symptoms associated with neuroleptics).

170. See Waller & Altshuler, *supra* note 5 (conceptual models of psychiatry used to better understand and counter patient noncompliance).

171. See Johnson, *supra* note 3, at 16; McEvoy, Howe & Hogarty, *Differences in the Nature of Relapse and Subsequent Inpatient Course Between Medication-Compliant and Noncompliant Schizophrenic Patients*, 172 J. NERVOUS & MENTAL DISEASE 412 (1984) (study compared factors relating to relapse rates of compliant and noncompliance chronic schizophrenics).

172. Johnson, *supra* note 3, at 16; Weller & Weller, *supra* note 155, at 44. For cases which display the relationship between noncompliance induced relapses and criminal behavior, see *United States v. Samuels*, 801 F.2d 1052 (8th Cir. 1986); *State v. Johnson*, 156 Ariz. 464, 753 P.2d 154 (1988) (en banc); *People v. Chavez*, 629 P.2d 1040 (Colo. 1981) (en banc); *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988); *Hill v. State*, 358 So.2d 190 (Fla. Dist. Ct. App. 1978); *In re Noel*, 226 Kan. 536, 601 P.2d 1152 (1979).

clinicians can excuse the pathological behavior of mental patients as due to factors beyond their control but do not invoke similar nebulous explanations for all the appropriate behavior of patients . . . This does not mean that the matter of responsibility is an either-or proposition; either patients are completely responsible for what they do or they are not. Obviously, many patients are much more aware of reality and able to manipulate it to their satisfaction than others. However, I do maintain that even for seemingly regressed or floridly psychotic patients, there is at least a kernel of will power, lurking somewhere in the nether regions of their minds and amid the maelstrom of thought and emotion, which can be employed constructively to counter and control their deviant impulses. No doubt it may require considerable effort for patients to master and channel these impulses, but this does not exonerate them from making a sustained effort to do so or from being receptive to outside therapeutic help.¹⁷³

Historically, mental illness had been viewed as a condition over which the actor could exercise no control.¹⁷⁴ It was as if a demon possessed the spirit, overriding the will of the individual and rendering him an agent of his illness.¹⁷⁵ With the advent of antipsychotic medication, a large measure of control was restored to the patient.¹⁷⁶ The patient on antipsychotic medication can now cause himself to be severely ill if he chooses not to comply with treatment.¹⁷⁷ If the patient's illness is in remission and he is responsible for self-administering medication, he may suffer a relapse as a result of noncompliance which would be, in essence, a self-induced incapacity.¹⁷⁸ These circumstances could potentially

173. A. LUDWIG, *TREATING THE TREATMENT FAILURES: THE CHALLENGE OF CHRONIC SCHIZOPHRENIA*, 38-40 (1971); see also A. GOLDSTEIN, *supra* note 28, at 26-29 (explaining that schizophrenics may be much "less 'crazy'" and may function more adequately than the general public expects).

174. See *supra* notes 153-54 and accompanying text.

175. See *supra* note 153 and accompanying text.

176. Sherlock, *supra* note 6, at 485.

177. For a discussion of the role that competency to make medical treatment decisions plays in a determination of responsibility, see *infra* notes 275-79 and accompanying text.

178. If a schizophrenic has the capacity to reason and chooses to become noncompliant with treatment he is disregarding the risk that he will become psychotic and that his illness will deprive him of his ability to reason. The decision to become noncompliant made by the schizophrenic will, in 80 percent of cases, result in psychosis. See Johnson, *supra* note 3, at 14-15. The cause in fact of a subsequent psychosis is noncompliance. As in the case of a person who has taken LSD and commits a criminal act while in a drug-induced psychotic state, the syndrome may appear to be schizophrenia for a short time. The only

give rise to criminal responsibility.¹⁷⁹

Currently, if a defendant can establish that he suffered from schizophrenia in the past and was experiencing an acute exacerbation of his psychosis at the time of the offense, he will be excused from criminal responsibility.¹⁸⁰ Courts, as a general proposition, will not inquire into the causes of mental illness as long as the mental illness is of a longstanding nature and was present at the time of the offense.¹⁸¹ The reluctance to consider the causes of mental illness is not justifiable in light of the degree of control exercised by the mentally ill over their own illnesses. Clearly, non-compliance can, and often does, cause mental illness.¹⁸² If the disabling symptoms of the illness are eliminated by medication and the actor is responsible for taking his medication, it is inappropriate to allow a noncompliance-induced relapse to be the basis of an insanity defense. If intoxication resulting in a state of psychosis at the time of an offense will not give rise to such a defense and if an epileptic in the throngs of a convulsive seizure can be criminally responsible for the harm that he causes while unconscious, certainly, a mentally ill offender who causes himself to become psychotic and causes harm should be criminally responsible as well.¹⁸³

reason for a legal distinction between the two syndromes is that in the case of a drug induced psychosis, the actor has caused the condition, whereas in schizophrenia, the actor normally does not cause the illness to be present. It is generally held that the act of taking a substance (and arguably, as here, not taking a substance) that the actor knows or should know is likely to have the effect of causing a loss of contact with reality should not give rise to exculpation. *Cf.* MODEL PENAL CODE § 2.08(1)-(2), (5)(b) (demonstrating the unavailability of a self-intoxication defense only for those crimes requiring the *mens rea* of recklessness).

179. Sherlock, *supra* note 6, at 485.

180. See *infra* notes 184-206 and accompanying text. Not all schizophrenics will be relieved of criminal responsibility especially if they cannot establish active symptoms at the time of the offense. See *United States v. Ives*, 609 F.2d 930 (9th Cir. 1979), *cert. denied*, 445 U.S. 919 (1980); *Robey v. State*, 54 Md. App. 60, 456 A.2d 953 (Ct. Spec. App. 1983).

181. See *State v. Maik*, 60 N.J. 203, 216, 287 A.2d 715, 722 (1972), *overruled in part*, *State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975).

182. Johnson, *supra* note 3, at 14-15 (over a 4-6 week period, noncompliance was observed in 40 - 48 percent of outpatients, and 45 - 65 percent of those in community treatment programs; of those receiving oral medication only 40 percent "survived" a two-year period without relapse, and of those who discontinued treatment completely only 20 percent "survived").

183. As one commentator has stated:

Perhaps worse than the inconsistent treatment of actors who cause the conditions of different defenses is the basic inconsistency, found in every jurisdiction, that arises when the law simply fails to account for some actors who cause the condi-

D. Cases

The legal significance of noncompliance was broached in *State v. McCleary*.¹⁸⁴ The defendant had a history of chronic paranoid schizophrenia that predated the criminal conduct by eleven years. He had been taking antipsychotic medication continuously since his first episode of illness,¹⁸⁵ until three or four days prior to going to a city park, disrobing, and wrestling a handgun away from a park ranger.¹⁸⁶ He was arrested and charged with robbery and pleaded not guilty by reason of insanity.¹⁸⁷ The court reviewed the psychiatric status of the defendant at the time of the act which supported his contention that he was insane at the time of the crime.¹⁸⁸ The trial court convicted the defendant, stating unequivocally that:

[T]here is a distinction between insanity and insanity that can be controlled. This may simply be the reverse of the law that applies where one induces his own "insanity," by becoming intoxicated and thereby engaging in wrongful behavior. Here this Defendant had the training, the experience, the opportunity and the medication with which to control his behavior He chose not to do that and, thereby, placed himself in the position where he was able to engage in anti-social and, indeed, criminal behavior.¹⁸⁹

On appeal,¹⁹⁰ the appellate court reversed on the grounds that the defendant had established his insanity defense by a pre-

tions of their defenses. Many states fail to consider an actor's causing his own defense in many instances where it may be relevant, such as causing . . . an insanity defense Yet every jurisdiction considers an actor's causing his own defense for some defenses, and every jurisdiction thus acknowledges that such causing-one's-defense can be relevant to an actor's liability. If it is relevant when an actor causes one defense, why is it not equally relevant when he causes another?

Robinson, *Causing The Conditions*, *supra* note 7, at 23-24.

184. *State v. McCleary*, No. CR49471 (C.P. Cuyahoga Cty., Ohio Nov. 19, 1979), *rev'd*, No. CR42116 (Ohio Ct. App. 8th Dist. Nov. 20, 1980) (LEXIS, States Library, Ohio file).

185. *Id.* at 12-13.

186. *Id.* at 11-13. The apparent cause for the defendant's noncompliance sprang from his wife's losing her job and a subsequent loss of income in the home, which created a good deal of stress on the defendant. *Id.* at 11.

187. *Id.* at 8-9. Apparently, the robbery charge stemmed from his taking the gun from the park ranger.

188. *Id.* at 10-28.

189. *Id.* at 44.

190. *State v. McCleary*, No. CR42116, (Ohio Ct. App. 8th Dist. Nov. 20, 1980) (LEXIS, States Library, Ohio file).

ponderance of the evidence. As to the trial court's conclusion that noncompliance with medication should give rise to responsibility, the appellate court concluded that in spite of demonstrating a cause for the defendant's illness, it did not rebut the existence of his mental disorder at the time of the offense.¹⁹¹

In *State v. Johnson*,¹⁹² the consequences of noncompliance were graphically laid out:

[The defendant] is a long-time victim of severe mental illness and has repeatedly been diagnosed as schizophrenic. Since the onset of his disease in approximately 1974, he has led a nomadic life, wandering from place to place, frequently being hospitalized after episodes of bizarre behavior. Prior to his arrival in Arizona, he had been hospitalized at least five times in Canada, Michigan, Washington and Utah. After being medicated and stabilized in the structured setting of a hospital, [the defendant] has suffered relapses upon his release. As he testified, "I get to feeling better and almost on top of the world so to speak, and I don't feel I need any help, so I quit taking my medicine."

After arriving in Arizona, [the defendant] was twice hospitalized at the Arizona State Hospital. He was released from his second hospitalization there on April 18, 1984 He again failed to follow through on his out-patient treatment or to take his medication On June 16, 1984, less than two months after his release, [the defendant] beat his arthritic, wheelchair-bound neighbor to death with a tire iron.¹⁹³

The defendant was acquitted as not guilty by reason of insanity.¹⁹⁴

In *United States v. Samuels*,¹⁹⁵ the defendant had been convicted for mailing letters threatening to take the life of the President of the United States.¹⁹⁶ He challenged the jury's finding that he was sane on the grounds that there was insufficient evidence of his sanity at the time of the offense. He had been previously diag-

191. *Id.* at 6. The appellate court missed the point. Noncompliance doesn't negate the existence of the illness nor insanity at the time of the offense. Noncompliance does evince that the offender has acted in disregard of potential risks associated with his illness. In short, it evinces culpability.

192. 156 Ariz. 464, 753 P.2d 154 (1988).

193. *Id.* at 465, 753 P.2d at 155.

194. *Id.* "As a result, each new insanity acquittal brings renewed cries of outrage that criminals are, literally, 'getting away with murder.' The law itself as seen as an enemy of social order rather than a safeguard." Bazelon, *The Dilemma of Criminal Responsibility*, 72 Ky. L. J. 263, 263 (1983-84) [hereinafter Bazelon, *The Dilemma*].

195. 801 F.2d 1052 (8th Cir. 1986).

196. *Id.* at 1053.

nosed as schizophrenic and had been responsible for administering his own medication.¹⁹⁷ At the time of the offense, the defendant was in the midst of a noncompliance-induced psychosis. The court stated that the defendant had:

[p]resented evidence . . . that when he was taking his medication his assaultive and threatening behavior would become stabilized. [He also offered evidence] that in the months preceding his arrest . . . he had not been taking his medication. Furthermore, [his] witnesses testified as to his long history of prior hospitalizations and treatment for his mental problems. [He] had a history of episodic illness which followed the pattern of events which occurred in the months prior to his arrest. 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, [he] would become hostile and exhibit paranoid schizophrenic behavior.¹⁹⁸

The court reversed the jury, finding that "the prosecution's evidence was so weak that a reasonable juror would necessarily possess a reasonable doubt as to [the] defendant's sanity."¹⁹⁹

In *Naidu v. Laird*,²⁰⁰ a wrongful death action was brought against a psychiatrist at the state hospital where one Hilton W. Putney had been in treatment.²⁰¹ Putney was involved in an auto

197. *Id.* at 1055.

198. *Id.* The court appeared to be aware of the causal role of noncompliance in inducing the defendant's incapacity. In addition to the defendant's testimony, the court was further persuaded by "the fact that [the defendant] had to be medicated in order to be found competent to stand trial. This is suggestive of how disturbed he could become when he did not regularly take his medication." *Id.* at 1055 n.2.

199. *Id.* at 1055 (citing *United States v. Voice*, 627 F.2d 138, 148 (8th Cir. 1980)). This case is representative of how a court will strictly adhere to the notion that a mental disease present at the time of an offense will give rise to an insanity defense, without regard to the etiology of the illness. The rationale for this principle is that:

[It is] unlikely that the inquiry would be useful, for when . . . the acute psychosis could equally be triggered by some other stress, known or unknown, which the defendant could not handle, a medical opinion as to what did in fact precipitate the psychosis is not apt to rise above a speculation among mere possibilities.

State v. Maik, 60 N.J. 203, 287 A.2d 715, 722 (1972), *overruled in part*, *State v. Krol* 68 N.J. 236, 344 A.2d 289 (1975). Where, as in the *Samuels* case, there exists a high degree of certainty as to the cause of the illness, the rationale does not support strict adherence to the principle, and failure to inquire into the cause of the illness is not justified. The cause in fact of the defendant's illness was his noncompliance with treatment.

200. 539 A.2d 1064 (Del. 1988).

201. The problem of the noncompliant schizophrenic offender extends beyond the initial inquiry as to whether he should be held liable. Once the standard for individual

accident while in a psychotic state resulting from his noncompliance with medication and deliberately drove his car into that of the decedent.²⁰² He was charged with manslaughter but was found not guilty by reason of insanity.²⁰³ Putney's eighteen-year psychiatric history was extensively documented by the court.²⁰⁴ Between

responsibility is established, it serves to "determine the responses we must make and even the questions we must ask in every other phase of the system - including police function and prevention, trial procedures, sentencing, and corrections." Bazelon, *Morality*, *supra* note 35, at 3-4. Once acquitted as insane, institutions and courts must struggle with the issues of how to insure that the illness will remain in remission and how to insure compliance with treatment. In *Hill v. State*, 358 So. 2d 190 (Fla. Dist. Ct. App. 1978), the court denied the defendant's petition for release, stating:

In this case the defendant, while in a most psychotic condition, perpetrated a most brutal homicide and his actions were of such depravity as to exhibit violent, destructive and bestial qualities with no inhibitions whatsoever . . . Now, this psychotic condition is merely in remission, held there by regular medication and constant supervision. A loss of remission . . . would expose the members of the public to unspeakable horrors, death and destruction.

Id. at 193-94.

Thus, courts are willing to consider a history of noncompliance, and it plays a major role in a court's treatment of an acquittee once release is sought. For example, in *People v. Washington*, 167 Ill. App. 3d 73, 520 N.E.2d 1160 (1988), *appeal denied*, 121 Ill. 2d 584, 526 N.E.2d 838 (1988), the court, in considering the appropriateness of involuntary commitment of a schizophrenic, stated:

The doctor testified that because defendant had no insight into his mental condition, minimized his problems, and did not perceive the need for . . . treatment, it was unlikely that defendant would continue treatment if he were not involuntarily admitted. [The doctor] also explicitly stated that defendant's schizophrenia would "continue" in the absence of medication, and that in this condition, defendant's harmful conduct . . . would probably recur. In light of this evidence, we conclude that the trial court properly ordered that defendant be involuntarily admitted . . .

Id. at 1163. See also Annotation, *Validity of Conditions Imposed when Releasing Persons Committed to an Institution as a Consequence of Acquittal on Grounds of Insanity*, 2 A.L.R. 4th 934 (1980) (surveying cases that address the propriety of imposing conditions on defendants acquitted of criminal charges by reason of insanity, as well cases considering the validity of the particular conditions imposed). For other tort actions brought against psychiatrist for act of mentally ill offenders, see *Currie v. United States*, 836 F.2d 209 (4th Cir. 1987) (psychiatrist liable in wrongful death action for failure to involuntarily commit patient who shot plaintiff's decedent); *Tarasoff v. Board of Regents of Univ. of Calif.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (psychotherapist who determines, or pursuant to standards of profession should determine, that a patient presents a serious threat of danger or harm to a third person incurs a duty to use reasonable care to protect the third person); *Canon v. Thumundo*, 430 Mich. 326, 422 N.W.2d 688 (1988) (government-employed psychiatrists' medical decisions with respect to a mental patient are cloaked with immunity, even if neglected); *Schuster v. Altenburg*, 144 Wis. 2d 223, 424 N.W.2d 159 (1988) (psychotherapist has duty to institute commitment proceedings if patient poses danger to himself or the public).

202. *Putney*, 539 A.2d at 1066-69.

203. *Id.* at 1066.

204. *Id.* at 1066-69.

1965 and 1977, Putney was hospitalized twenty-one times. The court noted that nine of these times were the direct result of Putney's refusing to take his antipsychotic medicine, and the court implied that noncompliance was often the precipitating factor in the twelve remaining hospitalizations.²⁰⁵ Also, the court noted six instances involving the police or criminal justice system, nine separate instances where civil commitment procedures were invoked, four attempts at suicide, and two previous deliberate auto accidents.²⁰⁶

These cases reflected the view that as long as a "true" mental illness resulting in a substantial impairment of the actor's cognitive and volitional capacities exists at the time of the offense, his conduct will not be punished. There are many reasons why this should not be the case. For example: 1) the degree of control exercised by the patient over the course of illness is high;²⁰⁷ 2) there is a high probability that noncompliance will result in relapse;²⁰⁸ 3) a direct causal relationship between noncompliance and relapse is clear;²⁰⁹ 4) there is a high recidivism rate of insanity acquittees/mentally ill offenders;²¹⁰ 5) the assumptions inherent in our crimi-

205. *Id.*

206. *Id.* Rather than hold Putney responsible, the Supreme Court of Delaware upheld a jury verdict of \$1.4 million against Putney's psychiatrist finding that he was negligent in:

disregarding his history . . . of a pattern of abandoning his medication and subsequent violent behavior; in failing to maintain proper records while he was in the Delaware State Hospital on this occasion; in failing to commit Mr. Putney involuntarily . . . in light of his condition and his failure to cooperate during his treatment; in unconditionally discharging Putney . . . ; in failing to place Mr. Putney in a program involving continuity of care and regular and frequent supervision and therapy; . . . and in failing to supervise, follow up or inquire in any way about Mr. Putney after his discharge

Id. at 1076 n.8.

Is the threat of harm to society lessened by acquitting Mr. Putney and holding his psychiatrist civilly liable for negligence, or would public sentiments be more satisfied and the aims of the criminal law better served if Mr. Putney were convicted of manslaughter and his psychiatrist relieved of tort liability? The question of whether a psychiatrist should be liable in tort for negligence under these circumstances is beyond the scope of this Note. If, however, Putney had been found criminally responsible for manslaughter, his actions, as an independent intervening cause to plaintiff's harm, should have relieved the psychiatrist from tort liability. In essence, the onus of responsibility for ensuring compliance lies with the patient, not the psychiatrist. However, under the circumstances in *Naidu*, imposing civil liability on the psychiatrist is viewed as appropriate by the author. See *infra* notes 264-66 and accompanying text.

207. See *supra* note 176 and accompanying text.

208. See *supra* note 182 and accompanying text.

209. See *supra* notes 184-206 and accompanying text.

210. See Bogenberger, Pasewark, Gudeman & Beiber, *supra* note 152.

nal justice system relating to criminal responsibility do not serve to justify exculpating noncompliant offenders;²¹¹ 6) the doctrinal exception to exculpation triggered by self-inducing an incapacity serves as a justifiable limitation on the insanity defense;²¹² 7) theoretical justifications typically used for not inquiring into the causes of mental illness do not apply to a noncompliant offender;²¹³ 8) and the potential for abuse of using one's frailty as an excuse is high.²¹⁴ As such, this Note urges that in considering the validity of a defendant's insanity defense, courts should examine the level of awareness entertained by a noncompliant offender when noncompliance occurred.²¹⁵ Further, where a clear and present danger to society exists as a result of noncompliance, and a defendant was aware of these risks, courts could justifiably hold a defendant responsible for risking madness.

The criminal law must continually develop effective means for distinguishing between individuals who should and should not be held responsible.²¹⁶ The collective voice of the people define what should be punishable, and the criminal law must at all times achieve parity with that voice to maintain its integrity and promote justice.²¹⁷ It must reward those who comply with norms by affording them full freedom, and it must punish those deserving of sanctions for violating social norms.²¹⁸ The substantial risk of

211. See *supra* notes 54-67 and accompanying text.

212. See *supra* notes 73-148 and accompanying text.

213. See *supra* note 199.

214. See *supra* notes 184-206 and accompanying text.

215. In determining the disposition of a noncompliant offender who causes harm and has an otherwise valid insanity defense, the prosecution should be required to allege noncompliance as satisfying the mental element of the offense at the time of indictment (when formally charged with the offense). At that point, it would be the defendant's prerogative to decide whether to come forth with an insanity defense. Arguably, the defendant could assert an insanity defense to the conduct constituting the harm done, as well as a justification defense to the conduct constituting noncompliance.

216. "One widely-stated goal of criminal law theory is to create the set of rules that best implements our collective sense of justice. To reach this goal, the theorist continuously adjusts his theory so that it generates rules that better reflect our fundamental notions of justice." Robinson, *Causing the Conditions*, *supra* note 7 at 1; see also Sellers, *supra* note 31 at 247 ("Harmony may be achieved by emphasizing the balance that must be struck between society's demand for maximum conformity to the prohibitions of the criminal law and the individual's just expectation not lightly to be deprived of his liberty, and by recognising as the most significant element in striking this balance the liability on conviction to imprisonment.").

217. Robinson, *Causing the Conditions*, *supra* note 7 at 1; cf. MODEL PENAL CODE § 1.02 (instructing courts to construe substantive Model Penal Code sections to further the general purposes of the Model Penal Code and that statute).

218. See MODEL PENAL CODE § 1.02 (1), (2) (stating purposes of punishing conduct

harm posed by those in psychotic states,²¹⁹ the societal interest in being free from inexcusable and unjustifiable infliction of substantial harm,²²⁰ the inconsistency in the insanity doctrine²²¹ and the clear causal relationship between noncompliance with treatment and psychotic relapse²²² indicate the need to refine the means used to distinguish between those who are and those who are not to be held responsible for criminal conduct. It is inconsistent to allow an actor who causes his own incapacity by becoming noncompliant with treatment to rely on the insanity defense, especially where the result is foreseeable and the potential for harm is very high.

II. PARADIGM AND ANALYSIS

A. A Paradigm Case: *Phillippe*

A brutal multiple homicide has recently taken place.²²³ The

that is beyond the social norm and safeguarding conduct within the social norm).

219. See *supra* text accompanying notes 184-206.

220. See *supra* note 35 and accompanying text.

221. See *supra* note 183 and accompanying text.

222. See *supra* note 182 and accompanying text.

223. The scenario presented here represents an amalgamation of the facts from several cases involving insanity and insanity acquitees. See *Dautremont v. Broadlawns Hospital*, 827 F.2d 291, 294 (8th Cir. 1987) (defendant with recurrent mental illness refuses psychotherapeutic drugs); *United States v. Samuels*, 801 F.2d 1052, 1055 (8th Cir. 1986) (discussed *supra* notes 195-99 and accompanying text); *United States v. Wright*, 627 F.2d 1300, 1304-05 (D.C. Cir. 1980) (religious zealot carrying out the will of the lord); *Carlisle v. State*, 512 So. 2d 150, 153-54 (Ala. Crim. App. 1987) (acquittee seeking release had schizophrenia held in remission by medication, denied release because of clear relationship between noncompliance and subsequent dangerousness); *State v. Johnson*, 156 Ariz. 464, 753 P.2d 154 (1988) (discussed *supra* notes 192-94 and accompanying text); *People v. Chavez*, 629 P.2d 1040, 1043-45 (Colo. 1981) (defendant with chronic schizophrenia with long history of criminal conduct and multiple previous hospitalizations for noncompliance, found not eligible for release because of a foreseeable risk of harm to himself and members of the community); *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988) (discussed *supra* notes 200-06 and accompanying text); *Hill v. State*, 358 So. 2d 190 (Fla. Dist. Ct. App. 1978) (acquittee denied release over concerns that noncompliance might result, with a relapse and foreseeable risk of harm to public); *In re Noel*, 226 Kan. 536, 553, 601 P.2d 1152, 1166 (1979) (noncompliant schizophrenic-first degree murder acquittee required to follow conditions under which compliance could be monitored so that dangerousness to self and others would be minimized if the court grants a conditional release); *Warner v. State*, 244 N.W.2d 640, 647 (Minn. 1976) (first degree murder acquittee with schizophrenia denied release because her illness held in remission by medication, might relapse with foreseeable risk of harm); *State v. Maik*, 60 N.J. 203, 212, 287 A.2d 715, 718-19 (1972), *overruled in part*; *State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975) (schizophrenic defendant appealing conviction of second degree murder after contributing to the presence of his illness by taking LSD and smoking hashish prior to offense); *State v. Junta*, 224 N.J. Super. 711, 714-17, 541 A.2d 284, 286-87 (Super Ct. App. Div. 1988) (defendant with schizophrenia, was told by voices to kill his girlfriend and appealed conviction for aggravated manslaughter);

victims, all members of a single family, were beaten to death. A 34 year-old male has been taken into custody in connection with the deaths. His name is Phillippe, an unemployed, white male who lived in a two-room apartment over the garage of the deceased family. Phillippe had been living there for five months and had taken residence in town after a three-month sojourn at the state mental hospital. He has been diagnosed as being afflicted with chronic paranoid schizophrenia.²²⁴

Over the past 17 years, Phillippe has drifted in and out of mental institutions. Sometimes he stayed for only a few weeks, and at other times, he stayed for many months or years. The best estimate of his total hospitalizations is 18 separate instances in six states. In all, he has spent 14 of the last 17 years in institutions. While hospitalized, Phillippe had been treated with an antipsychotic medication²²⁵ and had been given the responsibility for self-administering his medication on a daily basis. Most of his hospitalizations have been attributed to noncompliance with treatment.

Phillippe's hospital records indicate that when he becomes noncompliant, that is, when he stops taking his medication, he becomes acutely psychotic. He has been observed repeatedly acting out hallucinatory commands²²⁶ while in an unmedicated state. He was charged with assault and criminal trespass on two different occasions, pleaded not guilty by reason of insanity, and was acquitted both times. In 1972, Phillippe killed a couple as they slept in their home. He had discontinued his medication a week prior to the murders and testified that he was carrying out the "will of the Lord." He was adjudged not guilty by reason of insanity and spent the following 8 years at a state mental institution.²²⁷ During

Tobis v. State, 52 Wash. App. 150, 151-52, 758 P.2d 534, 535 (Wash. Ct. App. 1988) (following acquittal on grounds of insanity for murdering his wife, acquittee was unconditionally released from institution and subsequently killed two others);

224. See Appendix A for the DSM-III-R diagnostic criteria for chronic paranoid schizophrenia.

225. It is common practice to prescribe one of the following antipsychotic medications to control symptoms: Thorazine, Prolixin or Prolixin Decanoate, Haldol or Haldol Decanoate, Stelazine, Trilafon, Loxitane, Navane, Mellaril, and Mobar in the treatment of schizophrenia. K. BERNHIEM & R. LEWINE, *supra* note 153, at 123-28; Comment, *An Involuntary Mental Patient's Right to Refuse Treatment with Antipsychotic Drugs: A Reassessment*, 48 OHIO ST. L.J. 1135 (1987).

226. A hallucination in which the subject is directed by a hallucinatory voice to carry out acts described by the voice, is commonly referred to as an auditory command hallucination. Cf. AMERICAN PSYCHIATRIC ASSOCIATION, DSM III CASE BOOK, THE HEAVENLY VISION, 201 (1981).

227. See generally Pogrebin, Regoli, & Perry, *Not Guilty by Reason of Insanity: A*

his hospitalization, his medication was supervised and his behavior was effectively controlled. Upon release, he was required to consult with a therapist on an outpatient basis, but after some time passed, Phillippe moved out of state.

After arriving in town, Phillippe had taken a job in a local car wash. Phillippe lived and worked in town for five months as a productive member of the community. Five days before the killings, Phillippe received word that his mother had died. The news upset him to the extent that he stopped taking his medication. Within two days, his co-workers at the car wash noticed that Phillippe was mumbling to himself, smiling and laughing without any apparent stimuli, ignoring personal hygiene and having a strange look about him. He was in a florid psychotic state the day of the homicides. Acting out the command of God, he believed he was making lemonade when he killed the family. Phillippe has been brought to trial on four counts of murder and pleaded not guilty by reason of insanity.

B. Analysis

If we were to limit the inquiry of Phillippe's responsibility to the time of the offense, he would be found insane. We could establish that: 1) he suffered from the mental disease of schizophrenia; 2) he was without the capacity to appreciate that what he was doing was morally wrong because of his delusional belief that he was making lemonade and that he was commanded to do so by God; 3) that his lack of capacity was the result of or caused by his mental disease; and 4) his conduct was the result of a delusion and hallucinations rendering him merely an agent of his illness. If we adhere to a rigid view of insanity and inquire only into culpability at the time of offense, Phillippe would most likely be excused for his conduct. This narrow view ignores the fact that, while in a lucid interval, a mentally ill individual is properly a subject for punishment. Moreover, the rigid view offends the principle that one becomes a culpable moral agent when he induces his incapacity. To preserve and reinforce these basic notions, we should *not* limit the inquiry to an examination of his culpability at the time of the offense.

If, as in the epilepsy and intoxication contexts, we were to

expand the time frame to include in our examination the events that led to Phillippe's lack of capacity, we could choose to impose liability for his precedent conduct and focus on the risk taken, or subsequent conduct and focus on the harm done.²²⁸ The following two sections discuss the imposition of criminal liability for disregarding the risk and criminal responsibility for murder respectively.

1. Precedent Conduct

Prior to discontinuing medication, Phillippe was functioning fairly well. During the months that he worked in the car wash and lived in his apartment, it would be fair to say that he was responsible for his conduct and would be appropriately held responsible for criminal conduct committed while his illness was in remission.²²⁹ For the sake of argument, we may further assume that, during this "lucid" interval, Phillippe was aware of his need for medication, the effect his medication had in controlling his psychotic symptoms and the consequences of discontinuing medication. In essence, Phillippe was responsible for maintaining his own mental health and protecting the interests of society.²³⁰ This

228. See *supra* notes 73-149 and accompanying text.

229. "It has become black-letter law that, 'even an adjudged lunatic will be held criminally responsible for acts committed during a lucid interval.'" *Robey v. State*, 54 Md. App. 60, 74, 456 A.2d 953, 960 (1983) (quoting 21 AM. JUR. 2D *Criminal Law* § 52 at 171 (1981)); see also *United States v. Williams*, 483 F. Supp. 453, 460 (E.D.N.Y. 1980) ("[T]he numerous intentional and rational acts of [the] defendant . . . bespeaks an individual who could appreciate the nature and consequences of his conduct . . .").

230. If one accepts the proposition that a mentally ill patient is competent to make treatment decisions, to which culpability could be attached, then it would stand to reason that the patient is responsible for both the decision to discontinue medication and the ensuing result of such a decision. The presence of extraneous evidence of the person's capacities to function, such as a period of stable employment, of handling finances, of being involved in social relationships, of maintaining personal hygiene, of attending appointments, or of regularly taking prescribed medication, lends support to the proposition that the individual has the capacity to conform his conduct to the requirement of social order. The temporal relationship between the relapses and noncompliance with medication, and a high frequency of correspondence between the two, would further lend support to the individual's awareness of the negative consequences of his noncompliance. The concordance of episodes of noncompliance with acts of harming self or others, or frequency of contacts with law enforcement officials during periods of noncompliance, would substantiate that negative consequences were within the awareness of the patient. His noncompliance would then be morally reprehensible and could be offered as evidence of moral culpability.

In circumstances where the individual has not shown that he has the capacity to conform to social or criminal proscriptions, such as destitution, lack of insight, repeated self-destructiveness, or severe chronic symptoms of illness, the individual is not capable of being entrusted with the responsibility of self-administering medication, and he should be de-

responsibility, if not fulfilled, would lead to clearly foreseeable consequences including relapse, reemergence of symptoms and serious harm to others.²³¹ At the moment he chooses to no longer comply with treatment, he disregards a substantial and unjustifiable risk of harm,²³² and this represents a gross deviation from the standard of conduct which others would observe under the circumstances.²³³ His conscious disregard of the risks could give rise to criminal responsibility under the reckless endangerment approach of the Model Penal Code.²³⁴ Section 211.2 provides: "A person commits [an offense] if he recklessly engages in conduct which places or may place another person in danger of death or serious bodily injury" ²³⁵ This section provides a means for imposing punishment for conduct that "threatens societal interests . . .

prived of his freedom to move freely about society as he represents a substantial and unjustifiable risk to the public well-being. See *infra* notes 271-75 and accompanying text.

231. See note 201 for cases dealing with the issue of how noncompliance effects a court's decision on an insanity acquittees release from an institution. A recent study has suggested that insanity acquittees have a very high rearrest rate following acquittal. Bogenberger, Pasewark, Gudeman, & Beiber, *supra* note 152 (of 107 acquittees, 67 percent were arrested within an eight year period following their acquittal, 56 percent of those were arrested for felonies, and 27 percent of those were arrested while still under hospital care).

232. "His awareness of a condition which he knows may produce such consequences as here, and his disregard of the consequences, renders him liable for culpable negligence" *People v. Decina*, 2 N.Y.2d 133, 140, 138 N.E.2d 799, 804, 57 N.Y.S.2d 558, 565 (1956), and arguably, if the conduct represents a gross deviation from the standard of conduct of law-abiding persons, then for recklessness. See MODEL PENAL CODE § 2.02(2)(C).

233. In *Carlisle v. State*, 512 So. 2d 150 (Ala. Crim. App. 1987), the treating psychiatrist was asked what assurances existed to guarantee compliance with antipsychotic medication when considering whether to grant a conditional release to an insanity acquittee and responded that:

[W]hat I count on is that [the defendant] is an intelligent man with a good stable work record. He has had a[n] . . . awful experience in which he has done something that he would never do in his right mind and he has been through a great deal of misery already because of it. He knows the remedy. He knows how to prevent it. I don't think he would voluntarily turn away from the remedy that [would] expose himself to such hazard.

Id. at 153.

234. MODEL PENAL CODE § 211.2. In addition, the cases dealing with conditional release of insanity acquittees make clear that noncompliance plays a major role in shaping a court's final determination as to whether or not an acquittee will be released into the community. See *supra* note 201. If a risk of harm is present and noncompliance serves as the cause-in-fact for the occurrence of the risk, a court should not preclude an inquiry into the culpability of a mentally ill defendant with respect to noncompliance simply because of the definition of an insanity defense, or an inoperative and outdated concept of mental illness. See *supra* note 199.

235. MODEL PENAL CODE § 211.2.

that may or may not result in occurrence of the harm ultimately feared."²³⁶ If the threatened harm were to occur, other sections of the *Model Penal Code* would provide means for punishing the actor.²³⁷

To constitute recklessness, there must be a showing: 1) that the defendant was aware of a substantial, unjustifiable risk; 2) that the defendant consciously disregarded the risk; and 3) that disregarding the risk involved "a gross deviation from the standard of conduct that a law abiding person would observe in the actor's situation."²³⁸ In the case of noncompliance, the actor must be aware that noncompliance can lead to relapse and death or serious bodily harm to others.²³⁹ Similarly, if a substantial risk exists but the actor's disregard of that risk is justified under the circumstances, disregarding the risk will not constitute recklessness.²⁴⁰ Viewing the actor's disregard of the risk retrospectively, it must fall grossly below the standard of lawful conduct.²⁴¹ By limiting criminal liability to a mental state of recklessness or more, the mentally ill offender who does not have the capacity to be aware of the nature of the risks because of his illness would not be criminally responsible for becoming noncompliant.

The nature of the risk taken and the harm done serve to determine whether Phillippe should be criminally responsible for the

236. *Id.* § 211.2 comment 2. The section utilizes what Robinson would call an evidentiary rationale for imposing blameworthiness — that engaging in the risky conduct is sufficient evidence of blameworthiness to impose punishment even where no harm occurs. See Robinson, *Imputed Criminal Liability*, *supra* note 67 at 620.

237. MODEL PENAL CODE § 211.2 comment 2.

238. See *id.* § 2.02(c); *Id.* at § 211.2 comment 3.

239. While it is conceivable that a negligence standard could be used to impose criminal responsibility, doing so would involve an objective standard that could create considerable difficulties. The effects of the actor's illness on his mental capacities would have to be considered when determining whether he should have perceived the risk. *Id.* § 2.02(d). By asking what the defendant *should have* been aware of, rather than what he was *actually aware* of, the presumption that he *could have been aware* may not be valid. To rely on an objective benchmark seems inconsistent with our desire to acknowledge the significance of mental illness as it may affect individual capacity. To surmount the difficulty of quantifying the effect various symptoms may have on the ability of a schizophrenic to perceive reality, this Note takes the position that a requirement of awareness, based on a subjective inquiry, is preferred. *But see infra* note 278 and accompanying text.

240. Thus if the actor discontinues medication because of factors beyond his control, his conduct, under the circumstances, would not represent an unjustifiable risk. See *infra* notes 268-81 and accompanying text.

241. In view of the nature and purpose of his conduct and circumstances known to him, disregarding the risk must represent a gross deviation. MODEL PENAL CODE §§ 2.02(c), 211.2 comment 3.

precedent or subsequent offense. By limiting criminal responsibility to a mental state of recklessness or above for both the precedent and subsequent offenses, those who lack awareness of risks because of their illness will not be criminally responsible for either offense. Where harm does not occur but a reckless disregard of risks exists with respect to noncompliance, the actor would be appropriately held responsible for reckless endangerment. Where harm does occur, however, a reckless state of mind should be imputed to the subsequent offense and the actor held responsible for the harm done.²⁴²

2. Subsequent Conduct

In order to convict Phillippe for the harm he has done, it is necessary to establish his *mens rea* with respect to the harm. As discussed above,²⁴³ this may be accomplished in several ways. An examination of *mens rea* at the time of the offense will most likely lead to an unsatisfying result. His delusional belief that he was making lemonade at the time he was killing the people would negate *mens rea*. His disregard of risks would be of no consequence, and he would be acquitted. Because he does not entertain a *mens rea* at the time of the offense, it becomes necessary to examine his precedent conduct to establish a mental state to be imputed to the subsequent conduct.²⁴⁴

As discussed in the preceding section, because Phillippe acted recklessly and because harm was done, he could be held responsible for reckless homicide.²⁴⁵ If his disregard of the risks consisted of extreme recklessness, that is, under circumstances manifesting an extreme indifference to the value of human life, then he could be held responsible for murder.²⁴⁶

Some might argue that it would be inappropriate to punish Phillippe because he truly needs treatment. Moreover, it would serve no purpose to punish Phillippe because he is mentally ill.²⁴⁷

242. See, e.g., *id.* § 211.2 comment 2; see also Robinson, *Causing the Conditions*, *supra*, note 7, at 30-36 (an actor who creates the conditions of his defense, is culpable based on his state of mind at the time of the initial, defense-creating conduct).

243. See *supra* notes 95-148 and accompanying text.

244. See *supra* notes 134-48 and accompanying text.

245. See *supra* notes 229-42 and accompanying text. Phillippe's actions constitute manslaughter under the model penal code. MODEL PENAL CODE §§ 210.3, 211.2 comment 2.

246. See MODEL PENAL CODE §§ 210.3, 211.2 comment 2.

247. See *id.* § 4.01; Morris, *supra* note 34, at 503.

In disposing of the insane offender, however, our primary concern should be the interests of society to be free from substantial harm.²⁴⁸ The individual's interest in maintaining his freedom should be secondary.²⁴⁹ Where the actor's noncompliance represents recklessness, the arguments concerning deterrence,²⁵⁰ a lack of capacity,²⁵¹ and blameworthiness²⁵² are no longer valid justifications for withholding punishment. A resolution consistent with the principles of criminal responsibility and insanity would mandate the imposition of criminal responsibility for the harm done. The insanity defense would serve its purpose in allowing the exculpation of only those who lack the essential capacity of reason, and punishment would be meted out to those who are blameworthy and capable of being deterred. The noncompliant acquittee would represent less of a threat to society were he incarcerated.²⁵³

The distinction between long-term institutional confinement in a mental hospital and a prison is, in some respects, quite subtle. Each involves the deprivation of freedom and segregation from society. A prison sentence often entails a definitive period of time, while hospitalization may be for an indeterminate period of time. Each may also involve post-institutional conditions such as parole or a conditional release.

248. *State v. Carter*, 64 N.J. 382, 388, 316 A.2d 449, 452 (1974) ("Public safety is the primary concern in shielding the public from . . . those adjudicated insane They are an 'exceptional class of people' who have demonstrated their threat to society by committing an act harmful to others.") *overruled in part*, *State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975). For an overview, see Comment, *supra* note 225.

249. See *supra* note 31.

250. See *supra* note 32.

251. See *supra* note 54.

252. See *supra* note 56 and accompanying text.

253. The distinction between civil commitment and criminal confinement for the noncompliant psychiatric offender with respect to stigma, is minimal. For example, in *United States v. Wright*, 627 F.2d 1300, 1303 n.15 (1980) (citing Hearing Transcript of October 11, 1978) the defendant, in choosing not to assert an insanity defense stated as one of his reasons in choosing as he did was "to avoid 'a very deep humiliation': [I] 'would rather go around with the label of 'criminal' than 'mentally ill.'" See also R. WARNER, *supra* note 1, at 179 (American schizophrenics feel ashamed of their illness and degraded by treatment from doctors). For an argument that commitment of the mentally ill following acquittal serves as punishment, see Note, *Commitment Following Insanity Acquittal*, 94 HARV. L. REV. 605 (1981); Jacob, *The Right of the Mental Patient to his Psychosis*, 39 MOD. L. REV. 17, 41 (1976) ("The only purpose for which power can rightfully be exercised over any member of a civilized community against his will is to prevent harm to others His own good either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to forbear because it would be better for him to do so, because it would make him happy, and because in the opinion of others, to do so would be wise, or even right.") (quoting J.S. MILL, ON LIBERTY 13).

The perception of these forms of confinement, however, is quite different. For example, imprisonment involves retribution for wrongs committed against society; hospitalization involves no retribution. Imprisonment conveys the message that reckless non-compliance is intolerable and that punishment will be meted out. Hospitalization, however, sends mixed signals to the actor and society. The actor is given the impression that there is nothing wrong with noncompliance. Hospitalization also relieves the actor of the consequences of failing to fulfill his duty to society to preserve the "inestimable gift of reason." In essence, this creates the impression that the mentally ill can get away with murder. Rather than deterring this socially destructive behavior, hospitalization reinforces noncompliance by failing to hold the mentally ill responsible for their actions. Choosing hospitalization as opposed to incarceration disserves the goals of criminal law. If medication was available to the mentally ill while imprisoned, the principles underlying criminal responsibility, the interests of society, and the standards underlying exculpation would be enhanced.

One might argue that to the extent that one might impute *mens rea* from the precedent act or omission to the subsequent offense in order to find culpability is contrary to specifying criminal offenses, by definition, to a limited set of acts, circumstances and states of mind. However, the reasons for imputing the *mens rea* in cases of voluntary intoxication and epilepsy are equally applicable here.²⁵⁴ Because the precedent conduct caused the incapacity and represented the individual's disregard of a substantial and unjustifiable risk of death or serious bodily harm with respect to the subsequent conduct, it would be appropriate to hold him accountable for the harm done by imputing a *mens rea* to the subsequent offense.

Arguments against making noncompliance a criminal offense include the facts that chronic schizophrenics may entertain multivariant states of mind. Moreover, chronic schizophrenics may vary in their capacity to make treatment decisions or to responsibly engage in self-medication. Indeed, the vast majority of mentally ill persons are not criminally dangerous, nor do they represent inherent harm to society. Just as recidivist offenders exist in criminal populations, where a small proportion commit the majority of criminal offenses so too in a population of the mentally

254. See *supra* notes 130-48 and accompanying text.

ill, there may be a small proportion who commit the majority of offenses.²⁵⁵ Allowing for an analysis of the offender's mental state when he chooses to become noncompliant will give rise to punishment in accord with culpability for those recidivist offenders who may be "getting away with murder."²⁵⁶

One might argue that choosing to be noncompliant is too remote from the harm done and should not be viewed as a culpable act. This objection is answerable by examining the nature of the risk taken. If a schizophrenic like Phillippe knows that when he discontinues medication, a substantial and unjustifiable risk of harm to others will be created and if he chooses to take that risk, he has set in motion a chain of events where the probability of the occurrence of harm is very high. There is an inexorable link between his conduct and the resulting harm. He and he alone is in control of the circumstances which will give rise to harm. He has the capability of choosing to run the risk or choosing to avoid it.²⁵⁷ By choosing to become noncompliant, he has disregarded a risk of harm which he knew existed. The causal relationship cannot be denied nor made less significant in light of his underlying illness. The harm done by taking that risk may not occur for some time, but there is no reason to pause in concluding that his *mens rea* with respect to the harm should be no different from the *mens rea* with respect to the risk taken when the risk results in such harm.²⁵⁸

One might argue that the aims of criminal justice will not be served if we were to hold the reckless noncompliant psychiatric offender responsible. Yet here, the noncompliant offender represents a substantial and unjustifiable risk of harm to individual and social interests where he has acted out against society in the past after a noncompliance-induced relapse.²⁵⁹ Strictly adhering to the definition of insanity is not always the best means for differentiat-

255. Bogenberger, Pasewark, Gudeman, & Beiber, *supra* note 152.

256. Robinson, *Causing the Conditions*, *supra* note 7, at 30-36; Bazelon, *The Dilemma*, *supra* note 194, at 263.

257. *But see infra* notes 268-81 and accompanying text.

258. *See, e.g.*, MODEL PENAL CODE § 2.03.

259. *See United States v. McCracken*, 488 F.2d 406 (5th Cir. 1974).

Justice does not permit punishing persons with certain mental disorders for committing acts offending against public peace and order. But insane offenders are no less a menace to society for being held irresponsible . . . The community has an interest in protecting the public from antisocial acts whether committed by sane or insane persons.

Id. at 417 (quoting *Lynch v. Overholser*, 369 U.S. 705, 724 (1962) (Clark, J. dissenting)).

ing between those who are not appropriate subjects of punishment. If psychiatric patients will be less inclined to run the risk of non-compliance for fear of punishment, the incidence of violent crimes committed by psychiatric patients may decrease. The stabilized patient is more likely to be able to contribute productively toward socially acceptable ends. He would be deterred from becoming noncompliant with his medication and could be more inclined to contact his doctor or seek voluntary hospitalization to stabilize his medication prior to relapse. He, as well as other psychiatric patients, who have the capacity to administer their own medication will likely see that they have a responsibility to themselves as well as to others to comply with their treatment and to prevent relapse. Exculpation of a self-induced incapacity does not serve to safeguard faultless conduct. Rather, it may serve as a shield from responsibility where the mental illness is self-induced. A mentally ill criminal offender will not be allowed to rely on the insanity defense if he has culpably exposed others to a substantial and unjustifiable risk of harm by becoming noncompliant with treatment. Limiting the insanity defense to those who are truly not responsible for their own incapacity furthers the moral interests of society and improves social perceptions of the criminal law. The possibility that a psychiatric offender will be wrongfully disallowed the solace of an insanity defense would be minimal because the proposed limitation would require awareness of the risks.²⁶⁰

The social costs of violent crime far outweigh the imposition of an incentive to use due care on psychiatric patients who are aware of the nature of their illness and have the ability to minimize the risk of harm to others by maintaining compliance with treatment.²⁶¹ The individual right to choose between treatment alternatives is not in any way lessened by imposing a deterrent on

260. See *supra* notes 228-42 and accompanying text.

261. One court posed the choice in Judge Bazelon's words:

Judge Bazelon's figure is apt: the acquitees [previous] violent episode is likely to weigh against nominally competing considerations the way a wolf weighs against a sheep in the same scales: even if the sheep is heavier when weighed separately, somehow the wolf always prevails when the two are weighed together Keeping dangerousness on a tight leash is especially difficult where there is danger of murder, since the danger is admittedly grave and since its improbability, which theoretically discounts it, is extremely difficult to quantify. Moreover, once a man has shown himself to be dangerous, it is all but impossible for him to prove the negative that he is no longer a menace.

Hill v. State, 358 So. 2d 190, 202-03 (Fla. Dist. Ct. App. 1978) (quoting Covington v. Harris, 419 F.2d 617, 627 (D.C. Cir. 1969)).

those who choose not to continue treatment. If the individual wishes to enjoy the freedoms enjoyed by members of a society, he in turn must respect the rights of others to be free from substantial and unjustifiable risks of harm.²⁶² To say that one can choose to discontinue treatment and impose a clear and substantial risk of death or serious bodily harm to others, would be to argue that the right of an individual to enjoy this freedom exceeds the right of members of society to be free from unreasonable risks of harm.²⁶³

Further, imposing civil liability on psychiatrists as opposed to criminal liability on psychiatric patients does not serve to diminish the threat of harm to society.²⁶⁴ If Phillippe were to be confined to a mental institution after another insanity acquittal, nothing can deter him from repeatedly choosing to become noncompliant with treatment upon release. He would undoubtedly be repeatedly hospitalized for noncompliance because he has no reason to feel deterred from doing so. He can, quite literally, "get away with murder"²⁶⁵ as many times as he is released from an institution. If the reckless noncompliant schizophrenic were held responsible for the consequences of noncompliance, psychiatrists would less likely be exposed to tort liability because the onus of responsibility would be on the patient for his own recklessness. If the choice inherent in noncompliance is recognized and the mentally ill offender is held responsible for his own recklessness, his conduct alone would be the proximate cause of harm. A psychiatrist should not be exposed to tort liability when he releases a patient who has demonstrated the capacity to act responsibly with respect to his treatment. The psychiatrist will be less likely to discharge the patient to an unstructured environment that cannot provide support when noncompliance occurs. When a psychiatric patient has no insight into his illness and is unaware of his need for medication, he should not be given the sole responsibility of complying with medication.

262. Cf. MODEL PENAL CODE § 1.02(1)(a) (listing as a purpose in defining a criminal offense, "to forbid and prevent conduct that unjustifiably and inexcusably inflicts or threatens substantial harm to individual or public interests"). See generally Comment, *The Forcible Medication of Involuntarily Committed Mental Patients with Antipsychotic Drugs* - Rogers v. Okin, 15 GA. L. REV. 739 (1981) (the right of the individual to decide whether to accept or reject treatment must be balanced against society's interest in protection of the common good).

263. See *infra* note 271.

264. See *supra* notes 200-09 and accompanying text.

265. Bazelon, *The Dilemma*, *supra* note 194.

If a psychiatrist releases such a psychiatric patient without making assurances that the patient will continue to take his medication, there exists a no-win situation for society notwithstanding the fact that the victim can recover monetary damages from the psychiatrist.²⁶⁶

Finally, one might argue that the line should not be drawn at recklessness and that negligence should be enough. The difference between these levels is the requisite level of awareness. While recklessness requires the actor to be aware of the risks, negligence does not. Under negligence, the actor's failure to perceive the risk makes the act punishable.²⁶⁷ Punishing a mentally ill individual for failing to perceive a substantial unjustifiable risk would in essence amount to punishing him for being mentally ill and for lacking the cognitive capacity to perceive what others would consider patent. Maintaining the requirement of actual awareness ensures that the actor actually had the capacity to perceive and comprehend the risk. The requirement also ensures that the impact of one's mental illness on his cognitive capacity will be addressed.

In sum, imposing criminal responsibility on the mentally ill criminal offender who chooses to become noncompliant with treatment is consistent with the principles of criminal responsibility and further serves societal interests when the offender is aware of the nature of his illness and the significance of taking medication and is aware of the risk of harm to others in choosing to be noncompliant with treatment. Further, the causal link between the incapacity and the voluntary noncompliance is clear. This Note urges that noncompliance be considered in determining the validity of an insanity defense. A noncompliance-induced relapse should be brought in line with current doctrine by allowing inculcation of a mental state present during the precedent conduct with respect to the subsequent conduct, to the subsequent conduct itself. This is viewed as the most effective means for differentiating between levels of culpability.

266. If as in *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988), the psychiatrist was held responsible for Mr. Putney's noncompliance, one could imagine the same pattern repeating again and again. In other words, if after Mr. Putney were released from his current hospitalization, what would prevent him from becoming noncompliant again, killing another person, and then having the estate of the deceased suing his most recent psychiatrist. *See, e.g., Tobis v. State*, 52 Wash. App. 150, 159, 758 P.2d 534, 539 (1988) (judicial immunity precluded liability by health care professionals because it was ultimately the court who decided to release the patients).

267. *See* MODEL PENAL CODE § 202(2)(d).

C. Variations: The Line of Recklessness

While the forgoing analysis suggests that it would be desirable to impose responsibility on the noncompliant offender, criminal responsibility should not be imposed where recklessness cannot be established. The following section explores some of those circumstances in the context of the Phillippe case.

1. Indigency²⁶⁸

Suppose that Phillippe had not been living in an apartment and did not have a job, but rather lived on the streets and spent his nights in the city shelter, at bus stations or in abandoned buildings. Should he be held responsible for becoming noncompliant when he did not have adequate means to acquire his medication? What if he could have obtained his medication by making a concerted effort but failed to do so? Assuming again that he was aware of the ramifications of discontinuing medication and the effect his medication had on his illness but had no means of acquiring his needed medication,²⁶⁹ one might argue that he has not chosen to run the risk of harming others. Instead, exigent circumstances precipitated his illness, and he should not, therefore, be held responsible.

The answer to this scenario might turn on whether poverty and deprivation are excuses to criminal responsibility, but clearly

268. Because of the objective manifestations of the disorder, many schizophrenics are ostracized by their peers, rejected from their homes, and stigmatized by society. R. WARNER, *supra* note 1, at 172, 187, 285-301. They are frequently institutionalized for long periods in state hospitals, in part because of the difficulties in managing their behavior, and in part because of the drain on resources a long term illness can have on a family. *Id.* at 292-93. Those that effectuate release from institutions by being stabilized on medication, or restored to reason and released, are sometimes left homeless without any means of financial or emotional support. *Id.* at 308. Some wander the streets of large cities, reside in soup kitchens, abandoned buildings and indigent shelters. Weller & Weller, *supra* note 155; R. Warner, *supra* note 1, at 172-79. Some have no means of obtaining their needed medication, nor the wherewithal to recognize that they need help. This is not to say, however, that all schizophrenics are so disadvantaged. Many have supportive families, means of self-support, and structured living situations, and meaningful relationships with others. Some respond extremely well to medication, with a complete remission of symptoms. Others show sufficient improvement to be capable of holding down jobs for long periods and be self-supporting.

269. If the patient/offender had sought treatment but was denied because of administrative reasons and could not obtain his medication, he could not be held accountable for his noncompliance. For example, Weller & Weller, *supra* note 155, describe the case of a schizophrenic seeking treatment who was denied assistance "on the grounds that his abode, a bus shelter, was outside [agency] boundaries!" *Id.* at 45.

a distinction can be made between the thief who steals to feed his family and the indigent mental patient who cannot afford medication. The thief, in weighing the risk of his family's hunger against the benefit of stealing, subserviates social interests to that of his own. He chooses to risk apprehension and punishment in order to fulfill his own needs. Arguably, the indigent mental patient, has not chosen to so subserviate societal interests. Phillippe, the indigent, is far less culpable than Phillippe in the original situation. This is so because the circumstances serve to justify his conduct, and in light of the circumstances, his noncompliance may not involve a gross deviation from normal standards of conduct. Arguably, in this situation, the institution that released him onto the streets is relatively more culpable than Phillippe because it should have been aware that Phillippe had no means of acquiring medication. But if it could be shown that an indigent's noncompliance did in fact represent a gross deviation then responsibility could be imposed.²⁷⁰

2. Incompetency

Suppose that Phillippe had been adjudicated as incompetent because he lacked the capacity to handle his affairs, and suppose he had been confined to an institution just prior to the time of the offense. An adjudication of incompetency is not presumptive of insanity, nor does it preclude an individual's right to make medical treatment decisions.²⁷¹ Unless he had been adjudged incompetent

270. For example, if Phillippe had the medication available but didn't take it.

271. Some courts have found a constitutionally protected right to decide whether or not to submit to antipsychotic medication therapy. For example:

In *Rennie v. Klein*, a mental patient being forcibly medicated with Prolixin sought relief from the federal district court in New Jersey. That court held that the constitutional right of privacy included a competent patient's right to refuse antipsychotic drug medication in non-emergency situations. In an emergency the state's interest under its police power in protecting the patient and others from immediate harm would justify forcible treatment. Absent an emergency, or within seventy-two hours of initiation of forced emergency medication, the court required that the patient be afforded "some due process hearing" on the issue of competency and the advisability of continuing or initiating forced medication.

Comment, *supra* note 262, at 748 (1981) (footnotes omitted). In *United States v. Charters*, the court stated the standard to govern whether a person is competent to make a medical treatment decision regarding antipsychotic medication should be whether the person has followed a "rational process" in deciding, listing the following examples:

[I]t would not be a competent decision based on rational reasons if [defendant] refused medication out of a denial that he suffers from schizophrenia or out of a belief that the drugs will have effects that no rational person could believe them

to make medical treatment decisions,²⁷² there is no reason to forego an inquiry into his culpability in becoming noncompliant with treatment.

Conversely, one might argue that the fact that Phillippe was entrusted with the responsibility of administering his own medication should create a presumption that he should be responsible for his decision to discontinue his medication in light of apparent risks. The realities of mental health institutions and lack of a supportive community treatment settings often dictate that upon stabilizing symptoms with medication, a patient will be discharged irrespective of whether compliance with treatment can be monitored. Often, a pattern of relapse, hospitalization and stabilization, and discharge followed by relapse develops. The occurrence of relapse in such cases may be more presumptive of an incomplete mental health system rather than reckless mental patients.²⁷³ If the patient were instead discharged to a supportive, yet less restrictive environment where compliance could be monitored on a daily or weekly basis, the incidence of noncompliance might decrease.²⁷⁴ This is not to say that persons who are incapable of self-administering medication are often released and given the responsibility of doing so. Nor does this suggest that persons who are

to have. However, . . . [if defendant fears that he] may suffer substantial and irreversible harm, [this may] provide a rational basis for refusing the medication if supported by the facts.

829 F.2d 479, 496-97 (4th Cir. 1987), *superceded*, *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988).

272. For example in *United States v. Charters*, the defendant was indicted for making threats against the President of the United States, was found incompetent to stand trial and was committed for treatment. The government sought to forcibly medicate the defendant over his objections and succeeded in obtaining a court order to do so. On appeal of the order, the court of appeals reversed, pointing out that a finding of incompetence to stand trial is not dispositive as to whether the defendant was competent to make medical treatment decisions. The court stated, "[m]entally ill patients, though incapacitated for particular purposes, can be competent to make decisions concerning their medical care and thus treatment decisions involving mentally ill individuals raise difficult questions about the deference which must be accorded a potentially competent patient's desires." 829 F.2d at 488 (footnote omitted); *see also* Comment, *supra* note 225 (judgment of general incompetence leading to a patient's civil commitment does not preclude the right to participate in decisions regarding his own medication); Note, *supra* note 253 (under English law, admission to a mental hospital does not deprive the patient of the right to control the treatment he receives).

273. Caton, Goldstein, Serrano & Bender, *The Impact of Discharge Planning on Chronic Schizophrenic Patients*, 35 HOSP. & COMMUNITY PSYCHIATRY 255 (1984) (noting the importance of treatment after-care in preventing subsequent relapse).

274. *But see* Johnson, *supra* note 3, at 14 (noting that 6 to 8 percent of patients are noncompliant with oral medication while in a hospital setting).

given the responsibility of self-administering medication cannot be held criminally responsible for choosing to become noncompliant with treatment. It does point out that creating a presumption of responsibility in cases where the patient is given the responsibility of administering his own medication would not adequately serve to differentiate between those who are and those who are not culpable in choosing to become noncompliant.²⁷⁵

3. Intolerance of Medication

Suppose that Phillippe developed adverse reactions while taking his medication and chose to discontinue treatment because of the adverse effects he experienced. Suppose that he experienced oversedation or tardive dyskinesia²⁷⁶ and felt he could not do his work effectively under the dose prescribed. There are many side effects associated with the use of antipsychotic medication that may be extremely unpleasant to the patient²⁷⁷ which, viewed from the patient's perspective, do not justify continuing treatment. In many cases, these side effects may serve as the precipitant of non-compliance. Under the circumstances, could Phillippe be held criminally responsible for reckless endangerment or manslaughter if he discontinued medication to avoid the adverse effects of medication?

Phillippe's decision to become noncompliant, viewed solely in regard to his own self interests, would be justified. Certainly, he

275. As discussed above in the context of negligence/recklessness, *supra* notes 229-41 and accompanying text, it is very important to scrutinize the circumstances in which noncompliance occurs in order to ensure that culpable noncompliant offenders are punished in accord with the level of awareness entertained. Presuming that one who is given the responsibility to self-administer medication is competent to do so would disserve our desire to allow those who lack responsibility to go unpunished. For example if Phillippe, because of his illness, lacked the necessary insight to be aware that he needed medication, but was discharged in spite of this with the responsibility of administering his own medication, a presumption of responsibility and awareness would be unfounded.

276. Tardive dyskinesia is an involuntary movement disorder which may occur in patients receiving long term antipsychotic medication therapy. Johnson, *supra* note 3, at 17-18. For judicial notice of the effects of tardive dyskinesia, see *United States v. Charters*, 829 F.2d 479, 483 n.2 (1987), *superceded*, 863 F.2d 302 (4th Cir. 1988). See *infra* note 277 for other side effects.

277. Side effects experienced in patients taking antipsychotic medication include: (during initial treatment) allergic reactions, decreased blood pressure, skin sensitivity; (during long term treatment) akathesia (restlessness) (experienced in 21 percent of users), parkinsonian symptoms (motor retardation and rigidity) (experienced in 15 percent), dystonia (neck, head and face rigidity) (experienced in 3 percent), and tardive dyskinesia (involuntary muscle movements, typically of the mouth and tongue) (experienced in 3 to 6 percent). K. BERNHEIM & R. LEWINE, *supra* note 153, at 128-33.

would not wish to cause permanent harm to himself by taking medication. Yet, his decision is not made in a vacuum. In this case, when he chooses to become noncompliant, he is aware that discontinuing his medication is causally related to his harmful conduct. The probability of harm occurring is high. The magnitude of harm is high. In balancing his own interests against the interests of society, it must be determined whether his noncompliance is justified. Phillippe has a duty to society to preserve, to the best of his ability, the "gift of reason". His individual interests are secondary to those of society. If he chooses to put forth his interests over society's interests, in essence, he would be arguing that protecting his own physical health was more important than preventing the death of another by his own hands. This is too high a price to pay for an individual's interests.

If Phillippe had been given fair warning that under no circumstances should he decrease or discontinue medication without first consulting his physician, his noncompliance would certainly be unjustified. In addition, his disposition after the previous insanity acquittal for eight years would lead one to conclude that he could well have been aware of the adverse effects of the medication and the necessity to consult with his physician regarding these adverse experiences. The paradigm case of Phillippe deals with a patient who is aware of a substantial and unjustifiable risk of harm to others if he is noncompliant. In light of this risk the question would be, whether the decision to discontinue treatment because of side effects represent a gross deviation from the standard of care viewed in light of Phillippe's circumstances. Ultimately, this question turns on whether noncompliance is justified under the circumstances.²⁷⁸

4. Inefficacious Treatment-Lack of Awareness

Suppose that although Phillippe has been diligent in taking his medication, the medication has failed to reduce his psychotic symptoms during the entire 17 years of his illness. If his symptoms were so severe as to deprive him of his ability to identify the nature of the risks involved, he cannot be held responsible for

278. The potential exists for reducing Phillippe's *mens rea* with respect to noncompliance in light of the adverse effects of medication. In such a case, the argument that a negligence standard would jeopardize the import of mental illness as it impacts on cognitive and volitional capacity, see *supra* note 239, would not apply where his decision to become compliant was based on reasoned choice.

causing harm because he was not reckless in becoming noncompliant with treatment. To say that he should have been aware of the nature of the risks involved when his illness truly deprives him of the capacity to know that he is ill would relegate the significance of mental illness.²⁷⁹ It is conceded that in some cases, symptoms of schizophrenia can have this effect. As a precaution, the standard espoused herein would require an awareness of the risks. Without this requirement, the insanity defense as well as mental illness would lose significance as a safeguard for faultless conduct.²⁸⁰

5. Stress

In the hypothetical case above, it appeared that Phillippe had received word that his mother had passed away just prior to his decision to discontinue medication. Often, a stressful event such as the death of a loved one, rejection, or a major disappointment precipitates a relapse by way of noncompliance. What significance should attach to such stressors in determining whether noncompliance is culpable? Should the fact that stress preoccupied Phillippe's thoughts to the extent that he forgot to take his medication for three days reduce his culpability? Would it matter if he had been compliant with treatment for eight years and forgot only this instance when he received word that his mother had died?²⁸¹

Consider the distraught spouse who received word that her husband had just been killed in an auto accident. She leaves work and begins to drive home. Being preoccupied, she does not notice that she has run a red light and that a group of school children is crossing the street. She hits three children. Even if she had never been involved in an auto accident or never even received a parking ticket, she has still caused harm to others and should be punished. Even though her situation is unfortunate, the fact remains that she was to blame because she should have been aware of the children. If in the case of Phillippe, he was unaware of the risks of noncompliance and had been compliant for a long period of time but neglected to take his medication only after experiencing a significant stressor, it would be difficult to argue that he should be

279. See *supra* note 239.

280. But see *supra* note 278.

281. See, e.g., *Carlisle v. State*, 512 So. 2d 150, 153 (Ala. Crim. App. 1987) (compliant schizophrenic for eight years following first episode suffered loss of mother and father, kills his brother after becoming noncompliant with treatment).

held responsible. The lower the *mens rea* with respect to the risk taken, the closer one comes to the border of irresponsibility. By insisting on a higher degree of culpability, such as recklessness one moves closer to punishing a blameworthy actor. If awareness can be established and if it can be shown that he had consciously disregarded the substantial and unjustifiable risk of harm to others, notwithstanding stressful circumstances, it would be appropriate to punish him for harm that resulted from risking madness.

CONCLUSION

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. This Note has argued that to continue to ignore the significance of noncompliance is contrary to the aims of criminal law, contrary to the rationale of the insanity defense, and inconsistent with the treatment of voluntarily intoxicated and epileptic offenders who are culpable in causing the conditions of their excuse. Imposing responsibility where circumstances demonstrate the mentally ill offender has recklessly caused his illness is theoretically sound, morally justified and beneficial for society and the criminal law. In exploring the parameters of imposing responsibility on mentally ill offenders, it has become apparent that doing so requires a sensitive inquiry into the mental state of the individual at the time the noncompliance occurred. A careful and thorough analysis of the mentally ill offender's decision to become noncompliant with treatment in light of his illness and circumstances is suggested in order to insure that a distinction be retained in insanity cases — that those who cannot be said to have been at fault or to blame be excused, while those who “risk madness” be held responsible.

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Appendix A

THE AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS pp. 194-97 (3d ed. rev. 1987) defines chronic paranoid schizophrenia as follows:

“A. Presence of characteristic psychotic symptoms in the active phase: either (1), (2), or (3) for at least one week (unless the symptoms are successfully treated):

(1) two of the following:

(a) delusions

(b) prominent hallucinations (throughout the day for several days or several times a week for several weeks, each hallucinatory experience not being limited to a few brief moments)

(c) incoherence or marked loosening of associations

(d) catatonic behavior

(e) flat or grossly inappropriate affect

(2) bizarre delusions (i.e., involving a phenomenon that the person's culture would regard as totally implausible, e.g., thought broadcasting, being controlled by a dead person)

(3) prominent hallucinations [as defined in (1)(b) above] of a voice with content having no apparent relation to depression or elation, or a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other

B. During the course of the disturbance, functioning in such areas as work, social relations, and self-care is markedly below the highest level achieved before the onset of the disturbance (or, when the onset is in childhood or adolescence, failure to achieve expected level of social development).

C. Schizoaffective Disorder and Mood Disorder with Psychotic Features have been ruled out, i.e., if a Major Depressive or Manic Syndrome has ever been present during an active phase of the disturbance, the total duration of all episodes of a mood syndrome has been brief relative to the total duration of the active and residual phases of the disturbance.

D. Continuous signs of the disturbance for at least six months. The six-month period must include an active phase (of at least one week, or less if symptoms have been successfully treated) during which there were psychotic symptoms characteristic of Schizophrenia (symptoms in A), with or without a prodromal or residual phase, as defined below.

Prodromal phase: A clear deterioration in functioning before the active phase of the disturbance that is not due to a distur-

bance in mood or to a Psychoactive Substance Use Disorder and that involves at least two of the symptoms listed below.

Residual phase: Following the active phase of the disturbance, persistence of at least two of the symptoms noted below, these not being due to a disturbance in mood or to a Psychoactive Substance Use Disorder.

Prodromal or Residual Symptoms:

- (1) marked social isolation or withdrawal
- (2) marked impairment in role functioning as wage-earner, student, or home-maker
- (3) markedly peculiar behavior (e.g., collecting garbage, talking to self in public, hoarding food)
- (4) marked impairment in personal hygiene and grooming
- (5) blunted or inappropriate affect
- (6) digressive, vague, overelaborate, or circumstantial speech, or poverty of speech, or poverty of content of speech
- (7) odd beliefs or magical thinking, influencing behavior and inconsistent with cultural norms, e.g., superstitiousness, belief in clairvoyance, telepathy, "sixth sense," "others can feel my feelings," overvalued ideas, ideas of reference
- (8) unusual perceptual experiences, e.g., recurrent illusions, sensing the presence of a force or person not actually present
- (9) marked lack of initiative, interests, or energy

. . . .

E. It cannot be established that an organic factor initiated and maintained the disturbance.

F. If there is a history of Autistic Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present.

. . . .

. Chronic - [The time from the beginning of the disturbance, when the person first began to show signs of the disturbance (including prodromal, active, and residual phases) more or less continuously, is more than two years.]”

. . . .

Paranoid Type - “Preoccupation with one or more systematized delusions or with frequent auditory hallucinations related to a single theme [and without] incoherence, marked loosening of associations, flat or grossly inappropriate affect, catatonic behavior, [or] grossly disorganized behavior.”