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CARDOZO LAW REVIEW
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RESPONSIBLY IRRESPONSIBLE?: AN ANALYSIS OF
THE MEDICALLY NONCOMPLIANT OFFENDER’S
FEDERAL INSANITY DEFENSE

Geoffrey Andreu[†]

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INTRODUCTION

It is rush hour in Boston and a young girl boards a busy commuter train.¹ Shortly after, a strange man boards the same train and stands uncomfortably close to the girl.² As the train rolls on, the man begins inappropriately touching the girl, eventually moving his hand to her thigh.³ The girl pushes the man away, gets off the train at the next stop and reports the incident to a nearby police officer.⁴ Police officers shortly thereafter find and arrest the man responsible.⁵

Assume that this man had a few beers past his limit at happy hour and could not recall the incident due to his intoxication. In most states, there would be no legal difficulty finding this man guilty of a crime despite his inebriated condition.⁶

Now assume that instead of being drunk, the perpetrator had schizophrenia.⁷ While normally able to suppress his symptoms by using antipsychotic medication,⁸ he recently chose to stop taking this medication.⁹ When he touched his victim, he suffered delusions causing him to believe that she welcomed his advances.¹⁰ At trial, he raises the insanity defense.¹¹ Should this man still be convicted? This Note will argue that, in federal court, this man's insanity defense should not be rejected simply because he stopped taking his medication.

It is axiomatic in criminal law that a defendant cannot create the circumstances of his own defense.¹² Application of this truism has precluded defendants from raising a variety of legal defenses in criminal

¹ This scenario is based on the facts of *Commonwealth v. Shin*, 16 N.E.3d 1122, 1123 (Mass. App. Ct. 2014).

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.* at 1123–24.

⁶ In general, most jurisdictions do not allow intoxication caused by voluntarily drinking alcoholic beverages to serve as a defense for a “general intent” crime. See Paul H. Robinson, *Causing the Conditions of One's Own Defense: A Study in the Limits of Theory in Criminal Law Doctrine*, 71 VA. L. REV. 1 (1985).

⁷ J. STANLEY MCQUADE, *MEDICAL INFORMATION SYSTEMS FOR LAWYERS* § 5:64 (2d ed. 1993) (A person suffering from schizophrenia may experience delusions, illusions and hallucinations, and dissociation from his social environment.).

⁸ *Shin*, 16 N.E.3d at 1125.

⁹ *Id.* at 1125–26.

¹⁰ *Id.*

¹¹ *Id.* at 1124.

¹² Robinson, *supra* note 6.

cases,¹³ with some commentators going so far as to argue that this principle should apply equally to all such defenses.¹⁴ However, courts have been hesitant to extend its application to the insanity defense, with some courts implying that the philosophical basis of the insanity defense precludes any inquiry into how insanity came about.¹⁵ As a result, no court has yet rejected a defendant's insanity defense based solely on his medication noncompliance.

This may soon change. Psychiatrists argue that pharmacological developments over the past three decades give psychiatric patients unprecedented control over their symptoms.¹⁶ Nevertheless, treatment compliance among those suffering from schizophrenia has not improved proportionately.¹⁷ Recent studies also find that psychiatric patients who use antipsychotic and mood stabilizing medication commit violent crimes less frequently than those who do not take such medication.¹⁸ Moreover, several recent high-profile tragedies—such as the school shooting at Sandy Hook—have involved mentally ill perpetrators, thus reinforcing the widely held belief that the mentally ill can be dangerous.¹⁹ Calls for mental health reform are widespread and have been answered in the political sphere.²⁰ Against this backdrop, some have argued that a mentally ill criminal defendant's decision to not take medication is a moral choice that should preclude that defendant from raising the insanity defense.²¹

This was exactly the issue in *Commonwealth v. Shin*,²² in which a schizophrenic man failed to take his medication and subsequently groped a girl on the subway.²³ The prosecution argued that the

¹³ See *id.* at 2–3.

¹⁴ See *id.* at 24 (noting that every jurisdiction considers whether a defendant caused the conditions of his own defense to be relevant to at least certain defenses, and questioning why it should not be equally relevant in those jurisdictions to all defenses).

¹⁵ *State v. Maik*, 287 A.2d 715, 722 (N.J. 1972) (“We think it compatible with the philosophical basis of M’Naghten to accept the fact of a schizophrenic episode without inquiry into its etiology.”).

¹⁶ Zachary D. Torrey & Kenneth J. Weiss, *Medication Noncompliance and Criminal Responsibility: Is the Insanity Defense Legitimate?*, 40 J. PSYCHIATRY & L. 219, 221–22 (2012).

¹⁷ *Id.* at 222.

¹⁸ See, e.g., Seena Fazel et al., *Antipsychotics, Mood Stabilisers, and Risk of Violent Crime*, 384 LANCET 1206, 1211 (2014) (finding a reduction in the rate of violent crime among mentally ill individuals who were taking antipsychotic and mood stabilizing medications as compared with those who were not).

¹⁹ See, e.g., Jonathan M. Metzl & Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 AM. J. PUB. HEALTH 240, 240 (2015).

²⁰ *Id.* (noting that in the aftermath of the Sandy Hook shooting, several states passed laws requiring mental health professionals to report those who they believed to be dangerous).

²¹ See, e.g., Torrey & Weiss, *supra* note 16, at 221 (stating that the insanity defense is designed to prevent the criminal punishment of those who are not blameworthy for their mental state).

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

²³ See *supra* notes 1–10.

defendant's medication noncompliance should be evaluated using a framework designed to determine whether a defendant's drug or alcohol use that exacerbated a preexisting mental illness should preclude his insanity defense.²⁴ The trial court agreed that this framework should apply to medication noncompliance cases, and correspondingly found the defendant guilty.²⁵ While the appeals court ultimately reversed,²⁶ its reasoning left open the possibility for future attacks on the insanity defense.²⁷ More importantly, the appeals court implied that it may have been the first court to ever confront this issue.²⁸ As such, *Shin* may impact courts outside of Massachusetts, as other courts will lack binding precedent on this novel issue.

In particular, federal courts may look to *Shin* when attempting to resolve the effect of medication noncompliance on a defendant's insanity defense.²⁹ Federal doctrine precludes a defendant from successfully proving his insanity when voluntary intoxication has played any role in causing his mental condition.³⁰ However, federal circuit courts have not yet determined whether this doctrine should apply to strictly medically noncompliant offenders.³¹ Given the inevitability of such a challenge,³² courts will examine non-binding precedent in order to determine how to address this issue. When they do, *Shin* will not serve as a satisfactory model to resolve this issue.³³ Thus, this Note will focus on the federal system.

This Note will argue that the federal judiciary should not consider a defendant's failure to take prescription medication when evaluating that defendant's insanity defense unless the legislature specifically amends the statute governing the insanity defense.³⁴ Section I.A will demonstrate that *Shin* failed to fully justify, as a matter of law, that the medically noncompliant offender should always have the ability to raise

²⁴ *Shin*, 16 N.E.3d at 1126–27.

²⁵ *Id.* at 1126.

²⁶ *Id.* at 1129.

²⁷ See *infra* Part II.

²⁸ *Shin*, 16 N.E.3d at 1128 (“Whether the *Berry-DiPadova* analysis is proper in a case such as this is a difficult question and one for which our cases—and those of other jurisdictions—provide little guidance.”).

²⁹ See *infra* Sections I.A–B.

³⁰ See *infra* Section I.B.

³¹ The Tenth Circuit briefly considered the issue of whether the insanity defense should be available to a defendant who is insane only because he was suffering from withdrawal because he failed to take his prescription Klonopin—a benzodiazepine drug. *United States v. Fisher*, 278 F. App'x 810, 811, 813 (10th Cir. 2008). However, the court ultimately ruled on other grounds, and thus did not decide this issue. *Id.* at 813.

³² See *supra* text accompanying notes 16–21.

³³ See *infra* Part II.

³⁴ See *infra* Part V.

the insanity defense.³⁵ Section I.B will discuss the analogous federal doctrine.³⁶ Section I.C will describe how proposed scholarly solutions would have courts evaluate the medically noncompliant defendant's insanity defense.³⁷ Part II will show that *Shin's* reasoning failed to preclude the application of these proposed scholarly solutions in a way that is contrary to *Shin's* holding, and may be used in federal courts to preclude a medically non-compliant defendant's insanity defense.³⁸ Part III will demonstrate how that result would be contrary to a doctrinally sound understanding of the federal insanity defense.³⁹ Part IV will argue that judicially altering the insanity defense so that the medically noncompliant offender cannot raise it would be an inappropriate use of federal judicial power because federal courts cannot engage this issue without exceeding their institutional competency and violating the principle of separation of powers.⁴⁰ Part V will propose that federal courts should not consider a defendant's failure to take prescription medication when evaluating his insanity defense unless Congress addresses this issue.⁴¹

I. THE DOCTRINAL BACKGROUND

A. *The Berry-DiPadova Analysis as Applied in Commonwealth v. Shin*

As one of the first cases in the country to address this issue, *Commonwealth v. Shin* will serve as this Note's starting point to evaluate how federal courts should analyze the medically noncompliant defendant's insanity defense.⁴²

At the core of *Shin* was the *Berry-DiPadova* framework.⁴³ *Berry-DiPadova* is a doctrine designed to adjudicate the guilt of offenders who were mentally ill but were considered legally insane only because their illness was exacerbated by their voluntary consumption of drugs or alcohol.⁴⁴ As its name implies, this analysis was developed in

³⁵ See *infra* Section I.A.

³⁶ See *infra* Section I.B.

³⁷ See *infra* Section I.C.

³⁸ See *infra* Part II.

³⁹ See *infra* Part III.

⁴⁰ See *infra* Part IV.

⁴¹ See *infra* Part V.

⁴² *Commonwealth v. Shin*, 16 N.E.3d 1122, 1129 (Mass. App. Ct. 2014) (noting that there was "no guiding case law" upon which the trial judge could rely when deciding this issue).

⁴³ *Id.* at 1127–28 (discussing the relevance of the *Berry-DiPadova* analysis to the medically noncompliant defendant).

⁴⁴ *Id.* at 1127.

*Commonwealth v. Berry*⁴⁵ and *Commonwealth v. DiPadova*,⁴⁶ both of which involved defendants who were mentally ill, had ingested intoxicants, killed people shortly thereafter,⁴⁷ and raised insanity defenses at their trials.⁴⁸

The issue in *Berry* was whether the trial court properly instructed the jury on how to consider the defendant's intoxication in evaluating his insanity defense.⁴⁹ In Massachusetts, a defendant who raises the insanity defense must be found not guilty by reason of insanity unless the Commonwealth proves beyond a reasonable doubt that the defendant did not suffer from a mental disease or defect that caused him to lack substantial capacity to appreciate the wrongfulness of his conduct or conform his actions to the requirements of law.⁵⁰ While the jury was properly instructed on this standard, the appeals court noted that the jury instructions failed to address the defendant who was rendered insane only due to the interaction of drugs or alcohol with his mental illness.⁵¹ The court thus sought to create a jury instruction to clarify when a defendant could raise the insanity defense after having voluntarily consumed drugs or alcohol.⁵²

⁴⁵ 931 N.E.2d 972 (Mass. 2010).

⁴⁶ 951 N.E.2d 891 (Mass. 2011).

⁴⁷ In *Berry*, the defendant was diagnosed with bipolar and schizoaffective disorders, and had consumed alcohol prior to repeatedly striking the victim in the head with a cinder block until he died. *Berry*, 931 N.E.2d at 974–77. In *DiPadova*, the defendant was diagnosed with bipolar disorder, posttraumatic stress disorder, and attention deficit hyperactivity disorder, and had consumed cocaine on the night that he killed his former landlord. *DiPadova*, 951 N.E.2d at 893–94.

⁴⁸ *Berry*, 931 N.E.2d at 976; *DiPadova*, 951 N.E.2d at 895.

⁴⁹ *Berry*, 931 N.E.2d at 980. The court also noted that for the conviction to be reversed, an improper jury instruction would have had to have caused a “substantial likelihood of a miscarriage of justice” because the defendant did not object to the jury instruction at the trial level. *Id.*

⁵⁰ *Id.* This standard was established in 1967 in *Commonwealth v. McHoul*, 226 N.E.2d 556, 557–58 (Mass. 1967).

⁵¹ *Berry*, 931 N.E.2d at 982–83.

⁵² The jury instruction proposed by the appeals court was as follows:

A defendant's lack of criminal responsibility cannot be solely the product of intoxication caused by her voluntary consumption of alcohol or another drug. . . . However, a defendant is not criminally responsible if you have a reasonable doubt as to whether, when the crime was committed, the defendant had a latent mental disease or defect that became activated by the voluntary consumption of drugs or alcohol, or an active mental disease or defect that became intensified by the voluntary consumption of drugs or alcohol, which activated or intensified mental disease or defect then caused her to lose the substantial capacity to appreciate the wrongfulness of her conduct or the substantial capacity to conform her conduct to the requirements of the law. If you have a reasonable doubt as to whether the defendant was criminally responsible, you shall find the defendant not guilty by reason of lack of criminal responsibility. . . . Where a defendant has an active mental disease or defect that caused her to lose the substantial capacity to appreciate the wrongfulness of her conduct or the substantial capacity to conform her conduct to the requirements of the law, the

In response, the court crafted the following framework: if a defendant was legally insane solely because of his voluntary consumption of drugs or alcohol, then the jury should reject his insanity defense.⁵³ By contrast, if the defendant was legally insane before consuming alcohol or drugs, then the jury should find him not guilty by reason of insanity even if his illness was exacerbated by drugs or alcohol.⁵⁴ The court held that this would also be the outcome if the defendant had an active or latent mental disease that did not cause insanity on its own, but due to the voluntary consumption of drugs or alcohol, was activated or intensified to the extent that it caused such lack of capacity.⁵⁵ However, the court added a caveat to this last category; if the defendant knew or had reason to know that consuming drugs or alcohol would render him legally insane through the activation of a latent mental disease or intensification of an active one, then the jury should reject his insanity defense.⁵⁶

The following year, the *DiPadova* court emphasized the importance of the defendant's knowledge of the effects that drugs or alcohol would have on his mental illness when applying the *Berry* instruction.⁵⁷ The court noted that this issue was unclear after *Berry* because the evidence in that case did not address the defendant's knowledge about the effect that drugs or alcohol would have on his mental illness.⁵⁸ Thus, the court clarified this aspect by stating that an otherwise insane defendant who voluntarily consumed drugs or alcohol prior to his criminal conduct could be found guilty only if (1) prior to consuming drugs or alcohol, the defendant had capacity to appreciate the wrongfulness of his conduct; (2) the drugs or alcohol intensified an active disease or activated a latent disease, in turn causing a lack of capacity; and (3) the defendant knew or should have known that drugs or alcohol would have that effect on his illness.⁵⁹

Less than five years after *DiPadova*, prosecutors sought to extend this doctrine to the medically noncompliant offender in *Shin*.⁶⁰ There, the defendant was accused of assault and battery for groping a girl of fourteen years of age or older while riding the subway on January 20,

defendant's consumption of alcohol or another drug cannot preclude the defense of lack of criminal responsibility.

Id. at 984 (citations omitted) (internal quotation marks omitted).

⁵³ *See id.* at 983–84.

⁵⁴ *See id.* at 984.

⁵⁵ *See id.*

⁵⁶ *See id.* at 984, n.9.

⁵⁷ *Commonwealth v. DiPadova*, 951 N.E.2d 891, 901 (Mass. 2011).

⁵⁸ *See id.* at 900–01.

⁵⁹ *See id.* at 900.

⁶⁰ *See Commonwealth v. Shin*, 16 N.E.3d 1122 (Mass. App. Ct. 2014).

2011.⁶¹ The defendant was diagnosed with schizophrenia in 2005 and had been hospitalized six times between 2005 and 2009 as a result.⁶² While the defendant had been prescribed antipsychotic medication, an expert at trial testified that the defendant was not taking his medication for some time before the incident, and was consequently experiencing symptoms of schizophrenia.⁶³ These symptoms included an impaired ability to perceive reality, which may have caused the defendant to believe that his victim was welcoming his advances.⁶⁴ The expert concluded that as a result of these symptoms, the defendant could not appreciate the wrongfulness of his actions or conform his conduct to the requirements of law at the time of his offense.⁶⁵

The prosecution urged the court to extend the *Berry-DiPadova* analysis to this case—and reject the defendant’s insanity defense—because the defendant’s insanity resulted from his failure to take prescription antipsychotic medication.⁶⁶ While the trial court agreed with the prosecution, the appeals court refused this argument, and stated that a defendant’s failure to take antipsychotic medication should not alter the availability or outcome of his insanity defense.⁶⁷

While the appeals court sought to preclude *Berry-DiPadova*’s application to medication noncompliance cases as a matter of law,⁶⁸ the discussion that followed in fact weakened this holding.⁶⁹ In that discussion, the court listed several reasons to distinguish medication noncompliance from the interaction of intoxication with mental illness.⁷⁰ First, the court noted that psychiatric patients fail to take medication for a variety of reasons, and that unlike the ingestion of drugs or alcohol, such reasons are frequently not blameworthy.⁷¹

⁶¹ *Id.* at 1123.

⁶² *Id.* at 1124.

⁶³ *Id.* at 1126.

⁶⁴ *Id.* at 1125–1126.

⁶⁵ *Id.* at 1126.

⁶⁶ *Id.* at 1127–1128.

[H]ere, the question is not whether the defendant knowingly and voluntarily consumed alcohol or drugs that exacerbated his inability to understand the wrongfulness of his behavior or undermined his capacity to conform his behavior to the requirements of the law, but whether his *failure* to take prescribed medication had those effects. . . . Whether the *Berry-DiPadova* analysis is proper in a case such as this is a difficult question[.]

Id. (emphasis retained).

⁶⁷ *Id.* at 1128.

⁶⁸ *See id.* (“*Berry* and *DiPadova* have no applicability in a circumstance where the allegation is that the defendant’s lack of criminal responsibility arises only from a failure to take prescribed medication.”).

⁶⁹ *See id.* at 1127–29.

⁷⁰ *See id.* at 1127–28.

⁷¹ *See id.*

Additionally, the court noted that different medications require different amounts of time to take effect, and determining when a defendant stopped taking his medication and what his mental state was at that time would thus be difficult.⁷² The court additionally asserted that the *Berry-DiPadova* analysis is inappropriate for medication noncompliance cases because, unlike alcohol and substance abuse, failure to take medication does not cause mental illness, but rather leads to the manifestation of symptoms arising from a preexisting mental illness.⁷³ Finally, the court argued that using the *Berry-DiPadova* framework in the case of a medically noncompliant defendant cannot be confined to a logical stopping point, and thus could be used to justify finding any defendant guilty if that defendant previously took medication and later stopped.⁷⁴ As will be discussed, this reasoning fails to fully justify the holding.⁷⁵

After arguing that the *Berry-DiPadova* analysis should not apply, the court nevertheless cursorily applied the analysis to show that the defendant was not at fault for his own noncompliance, and thus could be acquitted due to his insanity even if the doctrine applied.⁷⁶ The court justified this by opining that the defendant may not have been sane even when he was compliant with his medication.⁷⁷ Additionally, no evidence had established that the defendant was ever compliant with his medication between his most recent hospital release in 2009 and his arrest in 2011.⁷⁸ Finally, the court noted that Mr. Shin may have been unable to obtain his medication due to insurance problems.⁷⁹ Thus, the court concluded that the defendant would not have been precluded from a successful insanity defense even if *Berry-DiPadova* applied because his failure to take medication either did not result in his insanity or was not voluntary.⁸⁰

[M]entally ill people fail to take prescribed medication for a myriad of reasons, including, for example, side effects that may be otherwise dangerous to their health. . . . In addition, some people are unable to obtain the appropriate medication because of lack of money or access to medical care, or problems with necessary paperwork such as may have occurred in this case.

Id. (citations omitted).

⁷² *Id.* at 1128.

⁷³ *Id.* As will be discussed, this distinction is blatantly erroneous, because *Berry-DiPadova* already distinguishes between situations in which drugs and alcohol cause insanity from situations in which symptoms of a mental illness are exacerbated—though not directly caused by—drugs or alcohol. *See infra* Part II. Here, medication noncompliance is analogous to the latter situation because both scenarios involve a preexisting mental illness.

⁷⁴ *Shin*, 16 N.E.3d at 1129.

⁷⁵ *See infra* Part II.

⁷⁶ *Shin*, 16 N.E.3d at 1128–29.

⁷⁷ *Id.* at 1129.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *See id.* at 1128–29.

While not binding on federal courts, the analysis discussed above is relevant to federal doctrine due to a lack of federal precedent, as well as similarities between the federal and Massachusetts insanity defenses.

B. *The Federal Insanity Defense*

In comparison to the *Berry-DiPadova* analysis, the federal system is even stricter in precluding voluntarily intoxicated, mentally ill defendants from being found not guilty by reason of insanity. To justify an insanity verdict in a federal case, a defendant must prove by clear and convincing evidence that at the time of the offense, he was unable to appreciate the nature and quality or the wrongfulness of his acts due to a severe mental disease or defect.⁸¹ Federal courts have long held that voluntary intoxication cannot be the cause of the mental disease or defect required for a successful insanity defense, nor can the defense be successful if the defendant is insane due, in any part, to the interaction of such intoxication with a preexisting mental illness.⁸²

These stringent requirements are based on the “rule,” as stated in prior cases, that a mental disease or defect for the purposes of the insanity defense must be brought about by circumstances outside of the actor’s control.⁸³ Though the federal insanity defense has changed in formulation over the years,⁸⁴ this “rule” is applicable to the present

⁸¹ See 18 U.S.C. § 17 (2012).

⁸² See *Kane v. United States*, 399 F.2d 730, 736 (9th Cir. 1968) (“[D]isability which [the defendant] does acquire from drinking liquor was within his own control and cannot be classified as a mental illness excusing criminal responsibility.”); see also *United States v. Burnim*, 576 F.2d 236, 237 (9th Cir. 1978) (“In evaluating Burnim’s mental state, the court was obliged to disregard whatever incapacitating effects were attributable to the voluntary ingestion of alcohol.”).

⁸³ *Kane*, 399 F.2d at 735 (“[T]he mental condition which produced such disability must have been brought about by circumstances beyond the control of the actor.”); *Burnim*, 576 F.2d at 238 (“[M]ental disability, however defined, must have been brought about by circumstances beyond the control of the actor.”).

⁸⁴ When *Kane* was decided in 1968, the Ninth Circuit applied the M’Naghten test for insanity. See *Kane*, 399 F.2d at 735. The key inquiry under the M’Naghten standard is whether “at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.” Charles Fischette, Note, *Psychopathy and Responsibility*, 90 VA. L. REV. 1423, 1442 (2004) (citation omitted). Ten years later, *Burnim* applied a modified version of the American Law Institute’s proposed standard for insanity. *Burnim*, 576 F.2d at 238. The current federal insanity defense, enacted as the Insanity Defense Reform Act of 1984, is codified at 18 U.S.C. § 17, and provides that: “It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.” 18 U.S.C. § 17(a) (2012). Additionally, “[t]he defendant has the burden of proving the defense of insanity by clear and convincing evidence.” *Id.* § 17(b).

insanity defense in many circuits, including the Second,⁸⁵ Third,⁸⁶ and Ninth.⁸⁷

Insofar as the federal insanity defense is currently governed by statute, federal courts have also deferred to legislative intent to prohibit the insanity defense when voluntary intoxication partially causes the defendant's mental state. In *United States v. Garcia*, the Second Circuit noted that Congress enacted the Insanity Defense Reform Act of 1984⁸⁸ (IDRA) to narrow the definition of insanity in response to "public concern" arising from the acquittal of John W. Hinckley, Jr.—the man who attempted to assassinate President Ronald Reagan.⁸⁹ Additionally, the Second and Ninth Circuits noted that in enacting the IDRA, the Senate Judiciary Committee expressly noted its intention to preserve the doctrine that excluded mental states arising from voluntary intoxication from constituting legal insanity.⁹⁰ Because Congress meant to narrow the definition and scope of the insanity defense and also exclude

⁸⁵ See *United States v. Garcia*, 94 F.3d 57, 62 (2d Cir. 1996) (stating that allowing a jury to consider the effect of voluntary drug or alcohol use on mental illness for an insanity defense would violate congressional intent to preclude availability of the insanity defense to defendants who lack capacity due to voluntary consumption of drugs or alcohol).

⁸⁶ See *United States v. Cuebas*, 415 F. App'x 390, 396 (3d Cir. 2011) (rejecting the defendant's argument that he should be granted an insanity instruction when voluntary intoxication exacerbated an underlying mental illness).

⁸⁷ *United States v. Knott*, 894 F.2d 1119, 1123 (9th Cir. 1990).

We hold that under the Insanity Defense Reform Act, the defendant's voluntary drug use or intoxication at the time of the crime may not be considered in combination with his mental disease or defect in determining whether the defendant was unable to appreciate the nature and quality or wrongfulness of his acts.

Id.

⁸⁸ Pub. L. No. 98-473, 98 Stat. 2057 (codified at 18 U.S.C. § 17 (2012)).

⁸⁹ *Garcia*, 94 F.3d at 61. A defense expert at trial stated that John W. Hinckley Jr. suffered from "process schizophrenia" at the time that he shot the President. Stuart Taylor Jr., *Shootings by Hinckley Laid to Schizophrenia*, N.Y. TIMES (May 15, 1982), <http://www.nytimes.com/1982/05/15/us/shootings-by-hinckley-laid-to-schizophrenia.html>. Hinckley was acquitted because he did not "appreciate" the "wrongfulness" of his conduct, as required for a criminal conviction in federal court at the time. Vincent J. Fuller, Symposium, *United States v. John W. Hinckley Jr. (1982)*, 33 LOY. L.A. L. REV. 699, 699–700 (2000). Hinckley's counsel stated it was "quite apparent . . . that [Hinckley] was mentally disturbed at the time of the 1981 shooting." *Id.* at 699. As evidence of Hinckley's detachment from reality, Hinckley's counsel referred to a letter that Hinckley wrote to actress Jodie Foster on the morning of the shooting. *Id.* at 700.

⁹⁰ *Garcia*, 94 F.3d at 61–62 ("Of significance to this case, Congress, speaking through the Senate Judiciary Committee, stated: 'The committee also intends that, as has been held under present case law interpretation, the voluntary use of alcohol or drugs, even if they render the defendant unable to appreciate the nature and quality of his acts, does not constitute insanity or any other species of legally valid affirmative defense.'" (citation omitted); *Knott*, 894 F.3d at 1121–22 ("Although the issue we address here is not the validity of an insanity defense based on voluntary intoxication alone, we are instructed by Congress's statements about voluntary intoxication. Prior to the Act, a majority of courts followed the rule that the mental effects of voluntary intoxication did not excuse responsibility for a criminal act. The legislative history demonstrates Congress's intent to carry this rule forward.") (citation omitted).

voluntary intoxication from giving rise to a successful insanity defense, courts have held that Congress must also have intended to prohibit an insanity acquittal when the defendant's mental state was caused by the interaction of voluntary intoxication with a preexisting mental disease or defect.⁹¹ Thus, unless the defendant was insane prior to taking drugs or alcohol, federal courts refuse to allow an insanity acquittal when the defendant's mental state was caused in any part by voluntary intoxication.⁹²

Federal circuits have yet to address whether this rule is applicable to a medically noncompliant defendant. However, the Tenth Circuit had the opportunity to consider a closely related issue: whether a defendant should be entitled to an insanity verdict when the defendant was experiencing withdrawal symptoms after failing to take prescription medication.⁹³ In *United States v. Fisher*, the defendant was an ex-convict who was prescribed Klonopin⁹⁴ to treat his anxiety disorder.⁹⁵ However, the defendant had not been taking this medication for some time before he illegally possessed a shotgun.⁹⁶ At trial, the defendant presented evidence that he was insane at the time of his conduct due to Klonopin withdrawal.⁹⁷ The trial court instructed the jury that if the jury found the defendant insane due to his voluntary failure to take prescription medication, and that he knew that such failure would bring about his condition, then they should reject his insanity defense.⁹⁸

On appeal, the government sought to have the jury instruction affirmed based on the principle that the defendant may not raise the

⁹¹ See *Garcia*, 94 F.3d at 62.

The government responds that 'combining a mental disease or defect that is itself insufficient under the IDRA, with the impermissible consideration of voluntary substance abuse, to result in a valid defense of insanity under the IDRA, is wholly illogical. This would constitute nothing short of rewarding the voluntary abuse of drugs and alcohol in direct contradiction of the intent of Congress in passing the IDRA.' The caselaw on this issue, although limited, recognizes as much, and we agree.

Id.; *Knott*, 894 F.2d at 1122 ("When we combine Congress's statements about voluntary intoxication with its clear intent to narrow the common law definition of insanity . . . we are persuaded that voluntary intoxication combined with a mental disease will not support an insanity defense under the Act.") (citation omitted).

⁹² See *supra* note 91.

⁹³ See *United States v. Fisher*, 278 F. App'x 810, 813 (10th Cir. 2008).

⁹⁴ Klonopin is a benzodiazepine which is used to treat panic disorders and seizures. Lauren Connell Pavelka, *Klonopin (Clonazepam)*, in 1 *ENCYCLOPEDIA OF CHILD BEHAV. AND DEV.* 855 (Sam Goldstein & Jack A. Naglieri eds., 2011).

⁹⁵ *Fisher*, 278 F. App'x at 811.

⁹⁶ *Id.* at 811–12.

⁹⁷ See *id.* at 812.

⁹⁸ *Id.* ("Over the defense's objection . . . the district court also instructed the jury that Fisher could not claim insanity if his 'condition was produced by [his] voluntary failure to take a prescription drug or [his] voluntary failure to obtain a prescription renewal and . . . that [he] knew that that failure would produce [his] condition.'").

insanity defense when insanity is caused in any part by drugs.⁹⁹ The defendant-appellant warned that because this case dealt with a failure to take drugs, such a ruling would be relevant to future defendants with schizophrenia who failed to take prescription medication.¹⁰⁰ However, the Tenth Circuit dodged this issue, and instead affirmed based on the “overwhelming evidence” that the defendant’s withdrawal was not severe enough to constitute insanity.¹⁰¹ Thus, there is no federal precedent instructing courts how to evaluate the medically noncompliant defendant’s insanity defense.

While there is a dearth of case law indicating how federal courts should handle this issue, scholars have proposed a number of solutions for courts to consider.

C. *Proposed Scholarly Solutions*

Some argue that failure to inquire into the source of the medically noncompliant offender’s symptoms¹⁰² does not accord with “moral intuition”¹⁰³—or a person’s intuitive feelings based on internalized

⁹⁹ *Id.* at 813.

¹⁰⁰ See Brief for Appellant at 17–18, *United States v. Fisher*, 278 F. App’x 810 (10th Cir. 2008) (No. 07-6161).

¹⁰¹ *Fisher*, 278 F. App’x at 813.

We need not decide whether or when such a withdrawal will support an insanity defense, because even assuming that insanity can be raised on the basis of withdrawal and that the district court erred in giving its limiting instruction, there is overwhelming evidence that Fisher was not suffering from withdrawal so severe as to render him insane at the times he possessed Knight’s shotgun.

Id. (citations omitted).

¹⁰² See, e.g., *State v. Maik*, 287 A.2d 715, 722 (N.J. 1972) (“We think it compatible with the philosophical basis of M’Naghten to accept the fact of a schizophrenic episode without inquiry into its etiology.”).

¹⁰³ “Moral intuitions” here refers to the argument made by many scholars that acquitting a medically noncompliant defendant seems intuitively unfair when the defendant knew or should have known the consequences of failing to take his medication. See Edward W. Mitchell, *Culpability for Inducing Mental States: The Insanity Defense of Dr. Jekyll*, 32 J. AM. ACAD. PSYCHIATRY & L. 63, 63 (2004) (“That Dr. Jekyll should be found not guilty of criminal acts committed while in his altered persona seems to be intuitively unjust. Is he not culpable, at least, for inducing a state in which he might commit such terrible acts?”); see also Richard Sherlock, *Compliance and Responsibility: New Issues for the Insanity Defense*, 12 J. PSYCHIATRY & L. 483, 486 (1984).

[I]f the patient had knowingly and willfully stopped taking his medication and had then relapsed into a manic state, would we not want to hold him responsible for being in a manic state for the harms he commits while in that state? Is he not at least partially to blame for those harms?

Id. at 488 (“Surely [holding the defendant responsible] seems more in keeping with our common moral intuitions than does the result achieved by a strict application of the standards found in the ALI version of the insanity defense or in any of the recent proposals for revision.”). One author

social norms of what acts should be deemed criminal. While scholars have proposed several solutions to align the law with these moral intuitions,¹⁰⁴ courts are most likely to adopt the proposal that medication noncompliance should be analyzed similarly to how courts analyze voluntary intoxication.¹⁰⁵ The following discussion outlines the doctrinal underpinnings of this approach.

A voluntarily intoxicated defendant may be found guilty through the imputation of mens rea.¹⁰⁶ Mens rea is generally defined as the state of mind that must accompany a criminal act for the defendant to be convicted of a crime.¹⁰⁷ When mens rea is imputed, it is transferred from an earlier time, at which a defendant possessed a culpable state of mind, to the time of the criminal conduct, when the defendant lacked such a mental state. For example, due to his intoxication, a person who is “black-out” drunk may not be able to form an intention to commit a crime at the time of his criminal conduct, and thus may lack the mens rea necessary to convict him of a crime.¹⁰⁸ However, courts and legislatures view the very act of voluntarily becoming intoxicated as a reckless one.¹⁰⁹ As such, the recklessness associated with becoming intoxicated is imputed to the later time at which the defendant cannot form any culpable mental state.¹¹⁰ In so doing, the prosecution is provided with the mens rea that is necessary to convict the defendant.¹¹¹

Likewise, the insanity defense also concerns the culpability of the

has defined “ethical intuition” as “the unconscious recognition of the moral qualities of an action without a resort to reason.” Eric C. Chaffee, *An Interdisciplinary Analysis of the Use of Ethical Intuition in Legal Compliance Decisionmaking for Business Entities*, 74 MD. L. REV. 497, 498 (2015); see also Mitchell, *supra* note 103, at 66.

¹⁰⁴ See Mitchell, *supra* note 103, at 66 (arguing that a criminal proceeding should be separated into three stages: “(1) determining guilt or innocence to the charge; (2) determining whether the defendant was suffering from a [defect of mind] (e.g., mental disorder, intoxication, substance abuse); and (3) determining the defendant’s level of culpability for that [defect of mind].”); see also Torry & Weiss, *supra* note 16, at 236–38 (arguing that medically noncompliant offenders should be prosecuted under reckless endangerment statutes for the purposes of using the criminal justice system therapeutically).

¹⁰⁵ See *supra* Section I.B–C. This proposal is particularly strong because it is based on existing legal doctrine.

¹⁰⁶ See Michael D. Slodov, *Criminal Responsibility and the Noncompliant Psychiatric Offender: Risking Madness*, 40 CASE W. RES. L. REV. 271, 288–89 (1989).

¹⁰⁷ *Id.*

¹⁰⁸ See, e.g., *United States v. Kenyon*, 481 F.3d 1054, 1070 (8th Cir. 2007) (“A defendant charged with a specific intent crime is entitled to an intoxication instruction when ‘the evidence would support a finding that [the defendant] was in fact intoxicated and that as a result there was a reasonable doubt that he lacked specific intent.’”) (citation omitted).

¹⁰⁹ See Robinson, *supra* note 6, at 15.

¹¹⁰ See *id.*

¹¹¹ See *id.* Robinson notes, however, that only recklessness may be imputed to the defendant in this situation. *Id.* Thus, a defendant may only be convicted of an offense which requires that the defendant acted recklessly—such as manslaughter—but may not be convicted of an offense in which the defendant must act with purpose or knowledge—such as murder. *Id.* at 14–15.

defendant's mental state at the time of his conduct.¹¹² Proponents of the imputation of mens rea for the medically noncompliant offender equate the insane defendant's lack of responsible agency at the time of a crime with the voluntarily intoxicated defendant's lack of consciousness with respect to a mental state that must accompany a material element of a crime. This facilitates the conclusion that, just as with voluntary intoxication, the prosecution should be able to impute a culpable mental state from an earlier point at which the defendant made an immoral choice—here, the decision not to take his medication.¹¹³

Under the imputation described above, a defendant could still be acquitted on insanity grounds if he did not have a culpable mental state regarding his noncompliance. For example, if a defendant truly did not realize that he would become insane when he stopped taking his medication, then he would not be acting recklessly when he failed to take his medication, and his insanity defense could still prove successful.¹¹⁴ By contrast, a defendant's insanity defense would fail if he understood that not taking his medication could lead to insanity, and nevertheless disregarded this risk.¹¹⁵ By allowing the defendant in the former example to go free while enabling the defendant's conviction in the latter example, this approach appears to comport with "moral intuitions"¹¹⁶ in a way that prohibiting inquiry into the source of insanity does not.

Shin did not adopt this approach, and instead sought to prohibit the factfinder from considering the defendant's medical noncompliance when evaluating his insanity defense.¹¹⁷ However, the court's reasoning in fact only justifies prohibiting the imputation of mens rea with a defendant who would have been acquitted under the *Berry-DiPadova* analysis anyway.

II. *SHIN*'S INADEQUATE REASONING

Chief among the court's reasons for not applying *Berry-DiPadova* in *Shin* was that, unlike drug or alcohol consumption, the mentally ill

¹¹² See Slodov, *supra* note 106, at 315 ("An examination of [the insane defendant's] 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.").

¹¹³ See *id.* at 311–12. ("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 [a noncompliant offender'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.").

¹¹⁴ See *id.* at 322–23.

¹¹⁵ See *id.* at 312–15.

¹¹⁶ See Mitchell, *supra* note 103, at 66.

¹¹⁷ See *supra* text accompanying notes 68–74.

fail to take medication for a variety of reasons, many of which are not culpable.¹¹⁸ The court made a point of noting that this was likely the case with Mr. Shin himself, who may have had difficulty obtaining his medication due to insurance complications.¹¹⁹ However, this issue can be remedied by allowing for an insanity acquittal when the noncompliance is involuntary or otherwise performed without a sufficiently culpable state of mind. *Berry-DiPadova* in fact already provides for this by allowing for an insanity acquittal in cases when the intoxication is involuntary, or when the defendant did not know or have reason to know of the effect that the drugs or alcohol would have on his mental illness.¹²⁰ Even the stricter rule applied by federal courts distinguishes based upon voluntary and involuntary intoxication, and thus could potentially exclude those like Mr. Shin, whose reason for noncompliance may have been beyond his control.¹²¹ Stated otherwise, if a defendant was not responsible for his treatment relapse, then even under *Berry-DiPadova* or the scholarly approach discussed above, he could be entitled to an insanity acquittal.¹²²

The court also contended that *Berry-DiPadova* should not apply to Mr. Shin because it would be difficult to determine when a defendant stopped taking his medication and what his mental state was at that time.¹²³ However, it is unlikely that a fact-finder would have more difficulty determining the prior mental state of a medically noncompliant offender than that of a voluntarily intoxicated defendant. Even assuming there is a difference, the prior mental state and efficacy of a defendant's treatment may be able to be proven through expert testimony. The efficacy of psychiatric medications,¹²⁴ their side

¹¹⁸ Commonwealth v. Shin, 16 N.E.3d 1122, 1127–28 (Mass. App. Ct. 2014) (noting that mentally ill people sometimes fail to take medication for health reasons, financial reasons, or administrative reasons, and that these reasons make the choice to become noncompliant with medication categorically different from than choice to consume drugs or alcohol).

¹¹⁹ *Id.* at 390.

¹²⁰ See *supra* text accompanying note 59.

¹²¹ See United States v. Garcia, 94 F.3d 57, 62 (2d Cir. 1996) (discussing only voluntary substance abuse and voluntary intoxication); see also United States v. Knott, 894 F.2d 1119, 1123 (9th Cir. 1990) (“We hold that under the Insanity Defense Reform Act, the defendant’s *voluntary* drug use or intoxication at the time of the crime may not be considered in combination with his mental disease or defect in determining whether the defendant was unable to appreciate the nature and quality or wrongfulness of his acts.”) (emphasis added). When intoxication is involuntary, courts typically find the *Burnim* exception to the insanity defense inapplicable. United States v. Henderson, 680 F.2d 659, 664 (9th Cir. 1982) (“Because the Government failed to introduce any evidence to rebut the evidence that Henderson’s drinking was involuntary, the *Burnim* exception to the insanity defense is inapplicable.”).

¹²² See *supra* text accompanying notes 112–118.

¹²³ *Shin*, 16 N.E.3d at 1128 (“[S]ome medications work better than others, or take time to become effective, and the difficulty of discerning when, exactly, someone stopped taking medication and what his mental state was at that time would be challenging at best.”).

¹²⁴ See, e.g., Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with*

effects,¹²⁵ and common reasons for medication noncompliance among the mentally ill¹²⁶ are issues that have generated a great deal of research.¹²⁷ Additionally, when a defendant takes antipsychotic medication, that patient often undergoes additional diagnostic tests and procedures after his initial treatment is prescribed.¹²⁸ This will create a “paper trail” which could allow a defendant to introduce evidence regarding the effectiveness of his treatment.¹²⁹ Thus, just as a forensic psychiatrist might use prior treatment evaluations and specialized knowledge to evaluate the effects of alcohol on a defendant’s mental illness, that psychiatrist could use similar methods to determine whether an antipsychotic medication was effectively treating a patient’s symptoms and why that patient might have stopped taking the medication.

Additionally, the court attempted to distinguish between medication noncompliance and voluntary intoxication by arguing that medication noncompliance, unlike voluntary intoxication, does not cause mental disease or defect.¹³⁰ However, this misstates the role of intoxication in *Berry-DiPadova*. That doctrine is aimed at determining whether a defendant should be found legally insane when an active

Chronic Schizophrenia, 353 THE NEW ENGLAND J. OF MED. 1209 (2005) (analyzing the relative effectiveness and rates of discontinuation of second-generation antipsychotic drugs as compared to older agents in patients with chronic schizophrenia).

¹²⁵ See, e.g., B.A. Ellenbroek, *Treatment of Schizophrenia: A Clinical and Preclinical Evaluation of Neuroleptic Drugs*, 57 PHARMACOLOGY & THERAPEUTICS 1, 18–31 (1993) (discussing the various adverse side effects of drugs which are widely used to treat schizophrenia).

¹²⁶ See, e.g., John L. Young et al., *Medication Adherence in Schizophrenia: A Forensic Review of Rates, Reasons, Treatments, and Prospects*, 27 J. AM. ACAD. PSYCHIATRY L. 426, 430–31 (1999) (describing risk factors which may lead to noncompliance, as well as methods for evaluating effectiveness of treatment in promoting compliance).

¹²⁷ See *infra* notes 124–26.

¹²⁸ The American Psychiatric Association’s Practice Guidelines for the Treatment of Schizophrenia recommend ongoing monitoring and assessment even after a patient “has achieved an adequate therapeutic response with minimal side effects or toxicity with a particular medication regimen.” AMERICAN PSYCHIATRIC ASSOCIATION, PRACTICE GUIDELINES FOR THE TREATMENT OF PSYCHIATRIC DISORDERS, 595–96 (2006). Such a patient “should be monitored while taking the same medication and dose for the next 6 months.” *Id.* at 595. This monitoring can result in useful insight into how the medication affected the patient.

¹²⁹ Under Massachusetts law, a patient has the privilege to refuse to disclose any communication between him and his psychiatrist in any Court proceeding, and may also prevent others from disclosing such information. MASS.GEN.LAWS. 233 § 20B (2001). However, a patient may waive this privilege, and would thus be able to produce assessments indicating that his medication was not effective. *Id.*

¹³⁰ *Commonwealth v. Shin*, 16 N.E.3d 1122, 1128 (Mass. App. Ct. 2014) (“The *source* of the lack of substantial capacity [was] the critical factor in determining whether the defendant [was] criminally responsible’ in those cases. . . . It strains that analysis considerably to apply it to a defendant such as this, because his mental illness is not *caused* by his failure to take medication, even though the medication might alleviate it somewhat or even entirely.”) (citation omitted) (emphasis retained).

mental illness is intensified or exacerbated by drugs or alcohol.¹³¹ By contrast, the analysis prohibits a defendant's successful insanity defense whenever the illness is caused solely by alcohol.¹³² Thus, *Berry-DiPadova* already distinguished instances in which a defendant's insanity was caused by alcohol from instances in which alcohol instead intensified or exacerbated that illness. By distinguishing medication noncompliance on this ground, the court inaccurately described the issue addressed by *Berry-DiPadova*.

Finally, the court noted that the Commonwealth's argument, when taken to its extreme, has no logical stopping point.¹³³ In other words, the court believed that it had no principled way to distinguish the defendant who brought on a schizophrenic episode by failing to take his medication last week from one who stopped taking his medication twenty years ago. While it may in fact be difficult to decide how far back the court should look before it no longer considers noncompliance relevant to an offense, this time-framing issue is not unique to medication noncompliance. For example, this issue frequently arises regarding the requirement that the defendant's conduct be voluntary.¹³⁴ This issue can be philosophically daunting to resolve, such that it may be impossible to determine beforehand when courts will apply a broad time frame and when they will apply a narrow time frame.¹³⁵ However, in practice, courts rarely have difficulty selecting a time frame which they believe is not too remote as to no longer have a just bearing on the

¹³¹ See *id.* at 1127 (noting that the *Berry-DiPadova* framework applies when a preexisting mental illness is exacerbated or intensified by voluntary intoxication.). Where insanity is produced solely by the voluntary consumption of drugs or alcohol and without any preexisting mental illness, then the defendant is precluded from raising the insanity defense.

¹³² See *Commonwealth v. Berry*, 931 N.E.2d 973, 984 (Mass. 2010) (“A defendant’s lack of criminal responsibility cannot be solely the product of intoxication caused by her voluntary consumption of alcohol or another drug.”) (citation omitted); see also *Commonwealth v. Sheehan*, 383 N.E.2d 1115, 1119 (Mass. 1978) (“If the defendant’s lack of substantial capacity to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law is solely the product of his voluntary consumption of drugs, he does not meet the McHoul test, even if he has a mental disease or defect.”) (citation omitted).

¹³³ *Shin*, 16 N.E.3d at 1129 (stating that when taken to its logical extreme, the argument advanced by Massachusetts in favor of finding a medically noncompliant defendant guilty “could be used to argue that every mentally ill defendant who had ever taken helpful medication in the past, but discontinued it, was criminally responsible. . .”).

¹³⁴ See Mark Kelman, *Interpretive Construction in the Substantive Criminal Law*, 33 STAN. L. REV. 591, 593–94 (1981) (“Often, conduct is deemed involuntary (or determined) rather than freely willed (or intentional) because we do not consider the defendant’s earlier decisions that may have put him in the position of apparent choicelessness. Conversely, conduct that could be viewed as freely willed or voluntary if we looked only at the precise moment of the criminal incident is sometimes deemed involuntary because we open up the time frame to look at prior events that seem to compel or determine the defendant’s conduct at the time of the incident.”).

¹³⁵ For a discussion which illustrates the difficulty in reconciling cases in which a narrow time frame was used with cases in which a broad time frame was used, see *id.* at 604–05.

defendant's culpability.¹³⁶ Thus, despite conceptual difficulties, courts and juries are well-equipped to handle this time-framing issue.

Shin's reasoning thus leaves a lot to be desired in setting out the categorical rule that the court sought to adopt. This might require future Massachusetts courts to consider whether *Shin's* reasoning was limited to its facts or if it should indeed be read as implementing a distinction as a matter of law between medication noncompliance and mental illness that is exacerbated by the voluntary use of drugs or alcohol. However, as one of the first courts to squarely address¹³⁷ this issue, *Shin* may have broader implications than its immediate impact in binding Massachusetts courts. This issue has rarely been addressed, and is thus likely to be an issue of first impression wherever it next arises. Just as the Massachusetts appeals court sought guidance in other state and federal decisions,¹³⁸ other courts may look to *Shin* as they encounter this issue.

Instead of relying on *Shin* and other proposed scholarly solutions, future courts should first clarify the role that mens rea doctrine plays in evaluating the medically noncompliant offender's insanity defense.

III. DOCTRINAL CONFUSION

As stated, precluding the medically noncompliant offender from successfully raising the insanity defense relies on the transference of mens rea from the time of noncompliance to the time of the criminal conduct.¹³⁹ Proponents of this view argue that this imputation is consistent with the law's treatment of the epileptic or voluntarily intoxicated driver who passes out at the wheel of his car, driving it into a victim and killing him.¹⁴⁰ However, any analogy between those scenarios and the medically noncompliant defendant relies on doctrinal confusion between the distinction of mens rea in the sense of a mental state that must accompany a material element of a crime, and mens rea

¹³⁶ Kelman suggests that discussions of these philosophical time-framing issues do not frequently appear in legal opinions because time-framing is an "arational" and "unconscious interpretive construct." *See id.* at 593–94.

¹³⁷ *See supra* note 47.

¹³⁸ The court determined that there were little to no cases from outside of Massachusetts' jurisdiction that would help resolve these issues. *See Shin*, 16 N.E.3d at 1128 ("Whether the *Berry-DiPadova* analysis is proper in a case such as this is a difficult question and one for which our cases—and those of other jurisdictions—provide little guidance.") (emphasis added).

¹³⁹ *See* Part I.C.; *see also* Slodov, *supra* note 106, at 283 ("Responsibility may be imposed . . . by imputing the mental state behind the precedent conduct to the subsequent offense.").

¹⁴⁰ *See* Slodov, *supra* note 106, at 273 ("Ignoring factors that contribute to the existence of the mental illness, specifically noncompliance with treatment, is contrary . . . to the judicial disposition of other self-induced incapacities like voluntary intoxication and epilepsy . . .").

in the sense of the general moral agency that a defendant is required to possess in order to be held responsible for his actions. For the sake of brevity, the former will be referred to as special mens rea,¹⁴¹ whereas the latter will be referred to as general mens rea.¹⁴² While the imputation of the former—as in the cases of epileptic and voluntarily intoxicated drivers—is founded in settled doctrine,¹⁴³ imputation of the latter—which would be necessary to preclude a medically noncompliant offender from a successful insanity defense—is unprecedented.¹⁴⁴ Thus, such an approach should be rejected by courts as a departure from settled doctrine.

Both the epileptic and voluntarily intoxicated driver scenarios represent the imputation of special mens rea. For example, if either an epileptic or intoxicated driver passed out at the wheel of his car and ran down and killed a pedestrian, then the driver would probably be charged with manslaughter.¹⁴⁵ A conviction under the federal manslaughter statute requires a showing that the defendant recklessly caused the death of a human being.¹⁴⁶ In that case, the special mens rea required by a charge of manslaughter would be recklessness, because in order to convict the defendant, the prosecution would have to prove that the defendant was reckless in relation to the material element of causing death.

Now assume that the driver of the vehicle passed out at the wheel because he was an epileptic who failed to take his medication and chose to drive.¹⁴⁷ Such epileptic person likely knew that if he failed to take his medication, he would be at a greater risk of suffering an epileptic seizure, and that if he drove a car and subsequently suffered a seizure,

¹⁴¹ See Stephen J. Morse, *Undiminished Confusion in Diminished Capacity*, 75 J. CRIM. L. & CRIMINOLOGY 1, 8 (1984) (“[S]pecial’ mens rea [is] the specific mental state element that is part of the definition of the crime and thus part of the prosecution’s prima facie case . . .”).

¹⁴² *Id.* at 8 (“[G]eneral’ mens rea . . . [is the] lack of responsibility that might be produced in whole or in part by factors such as legal insanity, duress, or partial responsibility.”).

¹⁴³ See *infra* text accompanying notes 151–155.

¹⁴⁴ See *infra* text accompanying notes 156–160.

¹⁴⁵ See, e.g., *United States v. Semsak*, 336 F.3d 1123, 1124 (9th Cir. 2003) (stating that a drunk driver that killed his victim after colliding with the victim’s vehicle was charged with involuntary manslaughter).

¹⁴⁶ The federal charge of involuntary manslaughter involves the unlawful killing of a human being, without malice, in the commission of a lawful act which might produce death “without due caution and circumspection.” 18 U.S.C. § 1112 (2012). While not explicitly stated in the statute, federal courts generally require a showing of recklessness to convict a defendant of involuntary manslaughter. See, e.g., *United States v. Garcia*, 729 F.3d 1171, 1177 (9th Cir. 2013) (holding that involuntary manslaughter conviction under 18 U.S.C. § 1112 required showing of gross negligence, which court defined as “wanton or reckless disregard for human life.”) (quotations omitted) (emphasis added).

¹⁴⁷ This situation is factually similar to *People v. Decina*, 138 N.E.2d 799 (N.Y. 1956). There, the defendant had a history of epileptic seizures and blacked out while driving, after which his car hit and killed four schoolchildren. *Id.* at 800–03.

he would place other motorists and pedestrians at a greater risk of injury or death.¹⁴⁸ Nevertheless, he chose to drive his car while off of his medication, suffered a seizure, and ran down a pedestrian. The problem with proving recklessness at the time of this offense is that the driver was unconscious, and therefore incapable of forming any mental state. However, the defendant was nevertheless reckless when he decided to drive his car after failing to take his medication because at that time, he consciously disregarded the risk of causing injury. Thus, by transferring this recklessness from an earlier point, the government can still prove a *prima facie* case.¹⁴⁹ Similarly, when a defendant disregards a substantial and unjustifiable risk that he might drive after becoming intoxicated, then his recklessness can be imputed from that earlier time point even if he blacked out and thus could not in fact form a reckless mental state while driving.¹⁵⁰

By contrast, the defendant who raises the insanity defense does not claim that he could not or did not form *mens rea* with regard to a specific element, but instead argues that he lacked general *mens rea*.¹⁵¹ This is a logically distinct concept from special *mens rea*, and presents different doctrinal issues.¹⁵² For example, if instead of being epileptic or intoxicated, the driver from earlier were in the midst of a schizophrenic episode and intentionally drove his car into his victim because he believed that doing so would impress a young Jodie Foster,¹⁵³ there would be no doubt that he was not only reckless as to causing death, but

¹⁴⁸ These, of course, could be a factual issue at trial, because the government would still have to prove that the defendant knew of and consciously disregarded a substantial and unjustifiable risk. *See id.* at 803–04.

¹⁴⁹ *See* Slodov, *supra* note 106, at 292 (“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.”).

¹⁵⁰ *See id.* at 293–94 (“If [the defendant] 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 appropriately held responsible for manslaughter.”). Note that this imputation falsely equates a general recklessness with recklessness as to a particular material element. Nevertheless, the impropriety of this false equivalency is outside of the scope of this note.

¹⁵¹ *See* Morse, *supra* note 141, at 8 (“Courts and commentators consistently fall prey to confusing ‘special’ *mens rea*, the specific mental state element that is part of the definition of the crime and thus part of the prosecution’s *prima facie* case, and ‘general’ *mens rea*, a generic term for lack of responsibility that might be produced in whole or in part by factors such as legal insanity, duress, or partial responsibility.”).

¹⁵² *See id.* (“A defendant who lacks special *mens rea* is acquitted because his conduct fails to satisfy the state’s definition of the offense, not because he lacks responsibility. The conduct of a defendant who lacks general *mens rea* almost always satisfies the elements of the *prima facie* case including special *mens rea*, but he is acquitted because he is not considered responsible for his conduct.”).

¹⁵³ John W. Hinckley Jr. may have attempted to assassinate President Reagan because he believed that it would impress actress Jodie Foster. *See* Taylor, *supra* note 89.

in fact intended to cause death at the time of the offense.¹⁵⁴ Despite the special mens rea requirement being satisfied, this defendant would still be able to raise the insanity defense on the grounds that he lacked general mens rea.¹⁵⁵

There may still be compelling policy justifications to preclude the medically noncompliant offender's insanity defense. For example, developments in antipsychotic medication over the past few decades have given patients effective treatment and unprecedented control over their symptoms, making the choice to exhibit symptoms a moral one.¹⁵⁶ Nevertheless, any such legal development cannot be disguised as a simple application of settled doctrine. Instead, this shift should be recognized as a departure from existing doctrine. Insofar as this new rule would be motivated by policy concerns, the judiciary is not the appropriate body to adopt such a rule. Instead, the legislature is the more appropriate political branch to promulgate this doctrinal shift.

IV. FEDERAL JUDICIAL POWER AND THE INSANITY DEFENSE

As stated, altering the federal insanity with respect to the medically noncompliant offender represents a policy decision and not an application of settled law.¹⁵⁷ The federal legislature—and not the judiciary—is the more appropriate branch to enact this change.¹⁵⁸ This is due to the constitutional doctrine of “separation of powers,” previously expressed legislative intent regarding the insanity defense, and the legislature's comparative competency to fashion a rule

¹⁵⁴ Such a defendant would be acting purposely insofar as it was his conscious objective to kill his victim, and he was aware that he was killing a human being. See MODEL PENAL CODE § 2.02. When a defendant's mental disease or defect negates special mens rea, the defendant is actually raising what is generally termed a diminished capacity defense. See Morse, *supra* note 141, at 5–7. That defense is surrounded by a host of controversy, with many commentators arguing that it is simply a failure of proof defense that should not be distinguished or treated differently from any other such defense. See *id.* Nevertheless, the effect that medication noncompliance would have on the diminished capacity defense is beyond of the scope of this Note.

¹⁵⁵ This argument is actually diminished capacity, not insanity. See Henry F. Fradella, *From Insanity to Beyond Diminished Capacity: Mental Illness and Criminal Excuse in the Post-Clark Era*, 18 U. FLA. J.L. & PUB. POL'Y 7, 47–48 (2007).

¹⁵⁶ See Sherlock, *supra* note 103, at 485 (“Both in legal punishment and moral blame we have a deep-seated sense that it is wrong to punish people for either acts they did not know were wrong or that they could not prevent themselves from doing. In the last decade, however, developments in psychiatric medicine have rendered this seemingly uneventful conclusion increasingly questionable. The most significant of these developments is our increasing capacity to control the most severe forms of mental illness with appropriate pharmacological management.”).

¹⁵⁷ See *supra* Part III.

¹⁵⁸ The features that a congressionally enacted law limiting the insanity defense should have is outside of this note. Moreover, such a law may be susceptible to constitutional challenge. See *infra* notes 186–187 and accompanying text. However, the hypothetical constitutionality of such a law is outside of the scope of this note as well.

reflecting “moral intuitions.”

A. *Separation of Powers and Clear Legislative Intent*

Prior to the IDRA’s enactment, the federal insanity defense was governed by case law.¹⁵⁹ Before Hinckley was found not guilty by reason of insanity for attempting to assassinate President Reagan,¹⁶⁰ most federal circuits applied the American Legal Institute’s standard of insanity.¹⁶¹ However, Congress responded to Hinckley’s acquittal by enacting the IDRA,¹⁶² which restricted the insanity defense’s availability by removing the volitional prong of the insanity defense,¹⁶³ requiring the mental disease or defect to be severe,¹⁶⁴ and shifting the burden to the defendant to demonstrate his insanity by clear and convincing evidence.¹⁶⁵ In essence, the legislature responded to public

¹⁵⁹ Joseph P. Liu, Note, *Federal Jury Instructions and the Consequences of a Successful Insanity Defense*, 93 COLUM. L. REV. 1223, 1231 (1993) (“Prior to 1984, there existed no uniform federal definition of criminal insanity. In the absence of a definitive declaration from either Congress or the Supreme Court, federal circuits enjoyed wide discretion in defining what constituted criminal insanity.”).

¹⁶⁰ Stuart Taylor Jr., *Hinkley [sic] Is Cleared but Is Held Insane in Reagan Attack*, N.Y. TIMES (June 22, 1982), <http://www.nytimes.com/1982/06/22/us/hinkley-is-cleared-but-is-held-insane-in-reagan-attack.html?pagewanted=all>.

¹⁶¹ See Liu, *supra* note 159, at 1231.

In the absence of a definitive declaration from either Congress or the Supreme Court, federal circuits enjoyed wide discretion in defining what constituted criminal insanity. Many circuits eventually adopted the definition set forth in the ALI Model Penal Code, under which a defendant was not held criminally responsible if he lacked ‘substantial capacity’ either (1) to appreciate the criminality of his conduct (the ‘cognitive’ test) or (2) to conform his conduct to the requirement of law (the ‘volitional’ test).

Id.

¹⁶² 18 U.S.C. § 17 (2012); see also *United States v. Garcia*, 94 F.3d 57, 61 (2d Cir. 1996) (“Congress enacted the IDRA, the first federal legislation on the insanity defense, largely in response to public concern over the acquittal of John W. Hinkley [sic], Jr. for the attempted assassination of President Reagan.”).

¹⁶³ S. REP. NO. 98–225, at 225 (1984) (“The principal difference between the statement of the defense in S. 1762 and that presently employed in the federal courts is that the volitional portion of the cognitive-volitional test of the ALI Model Penal Code is eliminated.”).

¹⁶⁴ *Id.* at 229.

The provision that the mental disease or defect must be ‘sever’ [sic] was added to Section 20 as a committee amendment. As introduced in S. 829, the provision referred only to a ‘mental disease or defect.’ The concept of severity was added to emphasize that non-psychotic behavior disorders or neuroses such as an ‘inadequate personality,’ ‘immature personality,’ or a pattern of ‘antisocial tendencies’ do not constitute the defense.

Id.

¹⁶⁵ *Id.* at 229 (“Significantly, the bill as reported shifts the burden of proof of the insanity defense to the defendant, who must demonstrate, by clear and convincing evidence, that his severe mental disease or defect caused him not to appreciate the nature and quality or

dissatisfaction with the judicially established insanity test by statutorily abrogating it.¹⁶⁶

However, in a report, the Senate Judiciary Committee noted its intention to maintain the doctrine prohibiting insanity from being a defense when the mental disease or defect is brought about by voluntary intoxication.¹⁶⁷ The Second Circuit interpreted this statement as unambiguous approval¹⁶⁸ of the doctrine precluding the insanity defense when the defendant is voluntarily intoxicated, even when a mental disease or defect is partly to blame for the resulting insanity.¹⁶⁹ However, unlike the broad formulations of this doctrine found in earlier cases,¹⁷⁰ the Senate Judiciary Committee discussed this doctrine only as it related to the voluntary consumption of drugs or alcohol.¹⁷¹ Thus, while it was previously plausible to read broad statements of this doctrine as relevant to the medically noncompliant offender,¹⁷² the Senate Judiciary Committee's precise language reveals the narrow scope of this exception. Courts have since relied on these statements in interpreting the IDRA, thereby incorporating them into federal doctrine.¹⁷³

By contrast, nothing in either the statute or the Senate Judiciary Report indicates that Congress meant to prohibit the defense for the

wrongfulness of his acts.”).

¹⁶⁶ See, e.g., Jay M. Zitter, Annotation, *Construction and Application of 18 U.S.C.A. § 17, Providing for Insanity Defense in Federal Criminal Prosecutions*, 118 A.L.R. FED. 265 (1994) (stating that Congress enacted the Insanity Defense Reform Act of 1984, which made the federal insanity defense more difficult to satisfy, as a response to the “public outcry and pressure surrounding the use of the insanity defense in the prosecution of John Hinckley for the attempted assassination of President Reagan.”).

¹⁶⁷ S. REP. NO. 98-225, at 229 (1984).

¹⁶⁸ See *United States v. Garcia*, 94 F.3d 57, 62 (2d Cir. 1996) (“Statements of congressional intent are rarely so clear.”).

¹⁶⁹ See *id.* at 61–62.

¹⁷⁰ See *Kane v. United States*, 399 F.2d 730, 735–36 (9th Cir. 1968) (“[T]he mental condition which produced such disability must have been brought about by circumstances beyond the control of the actor.”); see also *United States v. Burnim*, 576 F.2d 236, 238 (9th Cir. 1978) (“[M]ental disability, however defined, must have been brought about by circumstances beyond the control of the actor.”).

¹⁷¹ See S. REP. NO. 98-225, at 229 (1984).

The committee also intends that, as has been held under present case law interpretation, the *voluntary use of alcohol or drugs*, even if they render the defendant unable to appreciate the nature and quality of his acts, does not constitute insanity or any other species of legally valid affirmative defense.

Id. (emphasis added).

¹⁷² This is because early statements of the rule used broad phrasing that could be applicable to any situation in which the defendant's action or inaction somehow induced his insanity. See, e.g., *Kane*, 399 F.2d at 735–36.

¹⁷³ See *Garcia*, 94 F.3d at 61–62 (relying on the statement in the Senate Judiciary Report to determine how to apply the IDRA standard).

medically noncompliant offender.¹⁷⁴ While congressional silence regarding medication noncompliance leaves courts to fill in the gap, courts would be unreasonable to interpret this silence to mean that Congress would have intended to treat medication noncompliance and voluntary intoxication similarly when applying the IDRA. Congress frequently responds to drug and alcohol issues with criminal proscriptions, but does not typically do so for mental health issues. For example, Congress has made it a crime to manufacture, distribute, or possess various controlled substances¹⁷⁵ with the ultimate intention of curbing the use of such intoxicating substances.¹⁷⁶ By contrast, Congress has enacted mental hygiene legislation to combat medication noncompliance¹⁷⁷ but has not criminalized the refusal to take psychiatric medication.

There are several possible explanations as to why Congress addresses these issues differently. One explanation is simply that moral intuitions indicate that drug and alcohol consumption is more morally blameworthy than a failure to take prescription medicine.¹⁷⁸ This difference may also be explained by the Supreme Court's recognition that the Due Process Clause protects a liberty interest in refusing the forced administration of antipsychotic medication in various contexts.¹⁷⁹ Thus, a law attaching criminal penalties to the refusal to take medication could potentially raise substantive due process issues insofar as it criminalizes a defendant's exercise of his constitutionally protected liberty.¹⁸⁰ Whatever the reason, Congress has clearly addressed these issues differently in federal legislation.¹⁸¹ Thus, treating the two issues

¹⁷⁴ See S. REP. NO. 98-225.

¹⁷⁵ See 21 U.S.C. § 841(a)(1) (2012). Controlled substances under the act include, inter alia, heroin, cocaine, marijuana, and phenylcyclidine (PCP). See § 841(b)(1)(B). A defendant convicted under 21 U.S.C. § 841 may be sentenced to life in prison. See § 841(b).

¹⁷⁶ See, e.g., 21 U.S.C. § 801(2) (2012) (stating in the congressional findings supporting the Controlled Substances Act that the "improper use of controlled substances have a substantial and detrimental effect on the health and general welfare of the American people.") (emphasis added).

¹⁷⁷ See, e.g., 18 U.S.C. § 4243(g) (2012) (allowing the Attorney General to revoke an insanity acquittee's conditional discharge from a medical facility, and reinstate that noncompliant patient to a *medical facility*, for failure to adhere to a prescribed medication regimen).

¹⁷⁸ But see Mitchell, *supra* note 103, at 64–65 (noting the similarity between a defendant who induces insanity by consuming an intoxicant and a defendant who induces insanity by failing to consume medication).

¹⁷⁹ See, e.g., Washington v. Harper, 494 U.S. 210, 221 (1990) (recognizing that respondent had "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment").

¹⁸⁰ Whether such a law would actually be unconstitutional is outside of the scope of this Note. However, the appellants in *United States v. Fisher* argued that such a law imposes an affirmative duty on defendants to take medication and thus violates a recognized liberty interest under the Due Process Clause. See Brief for Appellant (with attachments in scanned PDF form) at 17, *United States v. Fisher*, 278 F. App'x 810 (10th Cir. 2008) (No. 07-6161).

¹⁸¹ See *supra* notes 175–177 and accompanying text.

identically when applying the IDRA would not only be outside of Congress's stated intent, but likely contradicts what Congress would have done had it expressly considered this issue.

In sum, the federal insanity defense is currently governed by statute.¹⁸² This indicates that Congress intended to control the federal insanity defense.¹⁸³ Courts have acknowledge this by stating that the IDRA must be applied according to its plain language and the underlying congressional intent.¹⁸⁴ The Senate Judiciary Committee asserted its intention to preserve the doctrine prohibiting an insanity defense when the mental disease or defect is brought about in any part by voluntary intoxication,¹⁸⁵ but was silent on the issue of medication noncompliance.¹⁸⁶ It is also unreasonable to argue that Congress would have precluded the insanity defense in such a scenario if it had expressly considered the issue.¹⁸⁷ Thus, a judicial expansion of this exception would contradict congressional intent and would depart from

¹⁸² See 18 U.S.C. § 17 (2012).

¹⁸³ See S. REP. NO. 98-225, at 222 (1984).

Title IV of the bill amends various provisions of Title 18, U.S.C. and the Federal Rules of Criminal Procedure relating to the insanity defense and the procedures to be followed in federal courts with respect to offenders who are or have been suffering from a mental disease or defect. The legislation includes a definition of the insanity defense that will substantially narrow the definition, which has evolved from case law, presently applied in the federal system. Title IV also provides that the defendant shall have the burden of proving the insanity defense by clear and convincing evidence and prohibits expert opinion testimony on the ultimate legal issue of whether the defendant was insane.

Id.; see also *United States v. Garcia*, 94 F.3d 57, 61 (2d Cir. 1996).

Congress enacted the IDRA, the first federal legislation on the insanity defense, largely in response to public concern over the acquittal of John W. Hinkley [sic], Jr. for the attempted assassination of President Reagan. In enacting the IDRA, Congress made two substantial changes to the federal insanity defense. First, it narrowed the definition of insanity that had evolved from the caselaw. Second, it shifted to the defendant the burden of proving the insanity defense by clear and convincing evidence.

Id. (citation omitted).

¹⁸⁴ See *Garcia*, 94 F.3d at 61 (“Because the charge is not covered expressly by the text of the Insanity Defense Reform Act of 1984 (‘IDRA’), 18 U.S.C. § 17, in examining the charge for error, we are required to look to the congressional intent behind the IDRA and to existing caselaw.”).

¹⁸⁵ See S. REP. NO. 98-225, at 229 (1984)

The committee also intends that, as has been held under present case law interpretation, the voluntary use of alcohol or drugs, even if they render the defendant unable to appreciate the nature and quality of his acts, does not constitute insanity or any other species of legally valid affirmative defense.

Id.

¹⁸⁶ Neither the statute nor the Senate report mention what effect, if any, a defendant's failure to adhere to a treatment regime should have on the defense. See generally 18 U.S.C. § 17 (2012); S. REP. NO. 98-225.

¹⁸⁷ See *supra* text accompanying notes 175–181.

the deference that the judiciary owes the legislature in a government of separated powers.¹⁸⁸

In addition to constitutional concerns, prudence also dictates that Congress is more well-adapted than the courts to craft a rule addressing the effect of a defendant's medication noncompliance on his insanity defense.

B. *Practical Consequences and Institutional Competencies*

Judicial deference to Congress on this issue is justified by institutional competencies—namely, the legislature's comparative competency to account for empirical considerations and exercise greater flexibility when crafting rules.¹⁸⁹ One empirical factor that would be outside of the court's concern when drafting a new rule is the amount of potential cases that could be affected by such a rule. A defendant's prior use of antipsychotic medication is highly correlated with a finding of not guilty by reason of insanity¹⁹⁰—in fact, nearly half of all successful insanity defenses involve defendants who previously used antipsychotic medication.¹⁹¹ Given that these offenders were insane at the time of their conduct, many of these individuals likely stopped taking their medication before committing their crimes.¹⁹² A rule precluding a defendant from successfully raising the insanity defense if he fails to

¹⁸⁸ See Craig W. Dallon, Note, *Interpreting Statutes Faithfully—Not Dynamically*, 1991 B.Y.U. L. REV. 1353, 1353 (1991) (“Our system of government anticipates that courts will construe and interpret statutes that legislative bodies enact.”).

¹⁸⁹ See Caitlin E. Borgmann, *Rethinking Judicial Deference to Legislative Fact-Finding*, 84 IND. L.J. 1, 8 (2009) (“In enacting a piece of legislation, a legislative body, generally through a committee, collects factual evidence relevant to the proposal. It then makes a policy judgment as to whether action is warranted in light of the facts.”).

¹⁹⁰ Richard Rogers et al., *A Study of Socio-Demographic Characteristics of Individuals Evaluated for Insanity*, 28 INT. J. OFFENDER THERAPY & COMP. CRIMINOLOGY 3, 7–8 (1984) (“Four socio-demographic variables were found to be significantly associated with both clinical and subsequent legal decision. Of these, prior histories of schizophrenia and psychoactive medication were highly correlated ($\phi = .68$) and were, as expected, associated with a finding of not guilty by reason of insanity.”).

¹⁹¹ See *id.* at 6. Of all factors that the study found relevant in predicting whether a not guilty by reason of insanity verdict would be reached, prior use of psychoactive medication was found to be tied with schizophrenia for the second highest correlation among defendants who successfully raised the defense. See *id.* at 8.

¹⁹² In addition to the intuitive conclusion that those who continued their treatment are less likely to exhibit psychotic symptoms, this is also probable given the high percentage of medication noncompliance among the entire population of patients prescribed antipsychotic medication. See Torry & Weiss, *supra* note 16, at 230–31 (“Over 50% of patients on antipsychotic medications exhibit full or partial nonadherence. Within 7 to 10 days of medication initiation, 25% stop taking the medication; 50% stop after 1 year; and 75% stop after 2 years. Only 33% of patients with mental illness reliably take medications as prescribed.”) (citations omitted).

take his medication thus has the potential to preclude the insanity defense for as many as half of those who would otherwise be able to successfully raise the defense.¹⁹³ The insanity defense is rarely raised, and even more rarely successful.¹⁹⁴ Thus, a doctrinal shift that may drastically limit the defense even further should not be made without first considering the full empirical extent of the change and whether it is warranted.

Additionally, courts are not adequately equipped to craft a rule accounting for the complexity of medication noncompliance. The judiciary often relies on traditional legal terminology when forming legal doctrine. For example, *Berry-DiPadova* conditioned the defendant's ability to raise the insanity defense on whether he knew or should have known of the effects of drugs or alcohol.¹⁹⁵ Use of these judicial heuristics may preclude the insanity defense when noncompliance occurs for other reasons that may not be blameworthy. For example, a schizophrenic man may stop taking his neuroleptic medication because it makes him severely depressed,¹⁹⁶ despite knowing that his schizophrenia would get worse if he stopped taking this medication. Some may consider this choice reasonable given the side effect. However, he could nevertheless be precluded from raising the insanity defense if the test focuses solely on whether he knew that he would exhibit psychotic symptoms if he stopped taking his medication.¹⁹⁷ Thus, the judiciary may not have the flexibility necessary to adequately address the nuanced issues inherent in medication noncompliance.

¹⁹³ While it cannot be assumed that the defendant would be found guilty every time medication noncompliance is an issue, it could nevertheless affect the outcome of any case in which the defendant had at one point taken medication. This is especially true if the federal judiciary were to simply extend the doctrine expressed in *Garcia*, and prohibit a successful insanity defense whenever but for the defendant's noncompliance, he would have been sane. *See United States v. Garcia*, 94 F.3d 57, 62 (2d Cir. 1996) (holding that allowing jury to consider effect of voluntary drug or alcohol use on mental illness for insanity defense would violate congressional intent to preclude availability of insanity defense to defendants who lack capacity due to voluntary consumption of drugs or alcohol).

¹⁹⁴ *See Fradella, supra* note 155, at 12 ("In fact, the insanity defense is used quite rarely. It is only raised in approximately 1% of all felony cases, and when invoked, the insanity defense is successful less than 25% of the time.")

¹⁹⁵ *See Commonwealth v. Shin*, 16 N.E.3d 1122, 1127 (Mass. App. Ct. 2014) (noting that pursuant to *DiPadova*, juries are instructed that a defendant is "criminally responsible if he knew (or should have known) that the consumption would have the effect of intensifying or exacerbating his mental condition . . .").

¹⁹⁶ *See Wayne S. Fenton et al., Determinants of Medication Compliance in Schizophrenia: Empirical and Clinical Findings*, 23 SCHIZOPHRENIA BULL. 637, 641 (1997) ("Neuroleptic side effects that may be particularly unpleasant include sedation, anticholinergic effects, cognitive blunting, depression, sexual dysfunction, and extrapyramidal syndromes—dystonia, akinesia, Parkinsonian effects, akathisia, and tardive dyskinesia.")

¹⁹⁷ *See Shin*, 16 N.E.2d at 1127.

The rigidity of judicial law-making¹⁹⁸ reflects the fact that the court's role is to interpret and apply the law to the facts before it.¹⁹⁹ As such, any judge-made rule is necessarily limited by the doctrine being interpreted and the facts of the case.²⁰⁰ Here, judges would be limited to interpreting whether mens rea could be imputed—as proposed by several scholars²⁰¹—and thus would focus on whether the defendant was aware of the risks when he stopped taking his medication.²⁰² This would not take into account that the mentally ill fail to take their medication for a variety of reasons, including adverse side effects, lack of family and social support, and practical barriers such as lack of money.²⁰³ Even if a case before the court implicated one of these factors, all of these factors cannot be expected to be present in a single case. Crafting a rule in response to one which adequately accounts for the others may be difficult in the judicial setting. Conversely, Congress has greater flexibility when crafting the law to tailor its policy to its findings of fact.²⁰⁴ Thus, the latter body is better suited to deal with the complexities surrounding this issue and navigate this landscape in a way that reflects moral intuitions.

Finally, insofar as prohibiting the insanity defense in medication

¹⁹⁸ See Roger J. Traynor, *No Magic Words Could Do It Justice*, 49 CALIF. L. REV. 615, 620 (1961).

¹⁹⁹ See Dallon, *supra* note 188, at 1353–54 (“The constitutional structure of our democratic system disapproves of any philosophy that invites calculated judicial lawmaking each time a statute is interpreted. Rather it calls upon the judiciary to interpret and apply the law to cases which come before it.”).

²⁰⁰ See Traynor, *supra* note 198, at 620 (“Many forces constrain review within extremely narrow limits. The most immediate constraint is the controversy itself that calls for decision; even the unprecedented controversy automatically precludes any ambitious excursion beyond its own context.”).

²⁰¹ See *supra* Part I.C.

²⁰² See Slodov, *supra* note 106, at 283 (“Responsibility may be imposed . . . by imputing the mental state behind the precedent conduct to the subsequent offense.”).

²⁰³ See Fenton, *supra* note 196, at 642.

²⁰⁴ See Borgmann, *supra* note 189, at 8; see also Sol Wachtler, *Judicial Lawmaking*, 65 N.Y.U. L. REV. 1, 16–17 (1990).

The judicial process may only be commenced by a person intimately and currently engaged in a dispute in which that person stands to be tangibly and personally injured unless government intervenes. In direct contrast to the legislature, where the lawmakers themselves have the final authority formally to commence the lawmaking process, the judiciary is completely barred from doing so. Moreover, the mode and extent of judicial inquiry, as compared to that of the legislature, is at once severely constricted in latitude and exponentially more intrusive in depth. The court's universe is limited to one particular real-life dispute, and its world is made up only of facts relevant to the origin, implications, and resolution of a discrete conflict. Unlike the legislature, in a conflict of any importance the judiciary issues an opinion which, if it is ‘worth its salt,’ positions the case in the contextual, historical, and cultural dimensions making up the legal landscape.

Id.

noncompliance cases reflects “our moral intuitions,” the legislature—and not the federal judiciary—is the appropriate branch to transform these intuitions into law.

C. “Moral Intuitions”

As previously stated, some scholars have argued that it is intuitively unjust to acquit a defendant who is at fault for causing the conditions of his own defense, even if he is insane at the time of his crime.²⁰⁵ At the core of this argument is the notion that the criminal law should reflect “moral intuitions” by attaching criminal penalties to behaviors that society deems immoral.²⁰⁶ As proof that “moral intuitions” support the conviction of the medically noncompliant offender, proponents of this argument point to voluntary intoxication as an analogous situation.²⁰⁷ Both situations involve a defendant voluntarily bringing about a state of mind—through either the ingestion of or abstinence from a mind altering substance—which would require the defendant’s acquittal if it were not willfully induced.²⁰⁸ More generally, both scenarios involve a defendant who may be culpable for creating the circumstances of his own defense.²⁰⁹ Thus, if our moral intuitions cannot distinguish between the wrongfulness of voluntary intoxication and that of medication noncompliance, and these moral intuitions are the driving force behind attaching criminal penalties to conduct, then one who commits the latter should not be set free so long as one guilty of the former is criminally penalized.

However, even assuming that moral intuitions should influence federal criminal law,²¹⁰ and that those moral intuitions demand that the

²⁰⁵ See, e.g., Mitchell, *supra* note 103, at 66 (noting that “[o]ur moral intuition” favors holding the medically noncompliant defendant “culpable for bringing about his murderous state”).

²⁰⁶ For example, Paul H. Robinson states that a “widely-stated goal of criminal law theory is to create the set of rules that best implements our collective sense of justice” in discussing his theoretical framework for addressing all situations in which a defendant creates the circumstances of his own defense. Robinson, *supra* note 6, at 1.

²⁰⁷ See Slodov, *supra* note 106, at 273

²⁰⁸ See *id.* (“Ignoring factors that contribute to the existence of the mental illness, specifically noncompliance with treatment, 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.”) (citation omitted).

²⁰⁹ As already noted, the criminal law generally seeks to prohibit a defendant from raising a defense when that defendant is responsible for creating the conditions of that defense. See generally Robinson, *supra* note 6.

²¹⁰ Whether the criminal law should embody community moral standards, or should instead embody less strict utilitarian principles, was famously the subject of “the Hart-Devlin debate.” See Jeffrie G. Murphy, Symposium, *Legal Moralism and Liberalism*, 37 ARIZ. L. REV. 73, 74 (1995). Some scholars note that those who expounded the idea that the law should reflect community morals were the clear losers in that debate. See Alice Ristroph, Symposium, *Third*

insanity defense not be available to the medically noncompliant offender,²¹¹ the federal judiciary is not the proper governing body to mold the law to these moral intuitions. Article III of the United States Constitution was framed with the intention to insulate federal judges from being influenced by social pressures.²¹² Insofar as these moral intuitions originate within society,²¹³ sensitivity to societal morality is crucial to properly converting these moral intuitions into law. By contrast, the institutional role of the federal judge is designed to shield that judge from the will of the people and their moral intuitions.²¹⁴ As a result, Article III judges are afforded numerous protections to preserve their institutional independence, including selection to life terms through presidential appointment instead of public election to time-limited terms.²¹⁵ This protection is intended to allow a judge to be guided by the law and render a judgment that might not accord with popular moral intuitions.²¹⁶

Conversely, a judge who makes a policy-driven decision often faces the criticism that he is substituting his own individual preferences for the law, instead of interpreting and applying the law pursuant to his institutional role.²¹⁷ This is especially true of criminal law, in which

Wave Legal Moralism, 42 ARIZ. ST. L.J. 1151, 1152 (2011). Nevertheless, resolving which legal philosophy should underlie the criminal law is outside of the scope of this Note.

²¹¹ *But see supra* text accompanying notes 174–179 (noting that Congress has previously treated voluntary intoxication as distinct from medication noncompliance).

²¹² *See* U.S. CONST. art. III; Vicki C. Jackson, Conference, *Packages of Judicial Independence: The Selection and Tenure of Article III Judges*, 95 GEO. L.J. 965, 969 (2007) (noting that the founders intended Article III judges, to be “independent of popular passions and certain kinds of pressures from other branches of the government”).

²¹³ Robinson’s reference to “*our collective* sense of justice” implies that the moral intuitions with which the criminal law should be concerned are held not just by a single individual, but by a broader social group. *See* Robinson, *supra* note 6, at 1 (emphasis added). Moreover, Murphy notes that Devlin—the primary proponent of legal moralism in the Hart-Devlin debate—was concerned with “violations of a *society’s* shared morality” when speaking of the moral intuitions that should give rise to criminal penalties. *See* Murphy, *supra* note 210, at 76 (emphasis added).

²¹⁴ *See* Jackson, *supra* note 212, at 969.

²¹⁵ *Id.* at 967–69.

²¹⁶ *Id.* at 969.

The harder question is what were judges to be independent to do? Some answers are: they were to be independent to judge according to law; they were to have the independence to *interpret* the law in order to render judgment; they were to protect minorities from popular passions that would violate their legal rights; and they were to check the other branches of government when they departed from the fundamental commitments set forth in the Constitution.

Id.

²¹⁷ For example, the Warren Court was widely criticized by members of all three branches of the federal government—particularly regarding its judicial reformation of criminal procedure—for engaging in “judicial activism.” *See* Charles J. Ogletree, Jr., Symposium, *Judicial Activism or Judicial Necessity: The D.C. District Court’s Criminal Justice Legacy*, 90 GEO. L.J. 685, 691–94 (2002). One commentator criticized the Warren Court for being guided by a “simple moral compass” instead of reasoned legal arguments. *See id.* at 694.

offenses are statutorily defined in the federal system and all states.²¹⁸ Thus, if a federal judge prohibited a medically noncompliant defendant from raising the insanity defense based on moral intuitions, that judge would risk overstepping his institutional bounds and writing his own policy preferences into an area of law governed by Congress.

Instead, Congress is the proper body to enact these moral intuitions into criminal laws. As elected officials, congressmen are more attuned to their constituents' moral intuitions.²¹⁹ Failure to adhere to these intuitions could lead to backlash at the polls, as members of Congress must be elected.²²⁰ In fact, Congress has already demonstrated sensitivity to moral judgments regarding the insanity defense when it passed the IDRA²²¹ amidst public dissatisfaction with John W. Hinckley Jr.'s insanity acquittal.²²² Thus, if the insanity defense is to be altered in medication noncompliance cases because of moral intuitions, Congress is the best suited branch to do so.

V. PROPOSAL

Federal courts should hold that a defendant's failure to comply with psychiatric treatment is irrelevant when evaluating that defendant's

²¹⁸ See Kevin C. McMunigal, *A Statutory Approach to Criminal Law*, 48 ST. LOUIS U. L.J. 1285, 1285 (2004).

The Supreme Court . . . announced almost 200 years ago that there are no federal common law crimes. As a result of the nineteenth century codification movement, every American state has for decades accepted the notion of legislative supremacy in Criminal Law—the idea that legislators rather than judges should create and define criminal offenses.

Id.

²¹⁹ See, e.g., *Furman v. Georgia*, 408 U.S. 238, 383 (1972) (Burger, C.J., dissenting) (“[I]n a democratic society legislatures, not courts, are constituted to respond to the will and consequently the moral values of the people.”).

²²⁰ Members of the House of Representatives are elected every two years. U.S. CONST. art. I, § 2, cl. 1. Members of the Senate are elected every six years. U.S. CONST. amend. XVII.

²²¹ See *supra* notes 159–166 and accompanying text.

²²² See Jay M. Zitter, *Construction and Application of 18 U.S.C.A. § 17, Providing for Insanity Defense in Federal Criminal Prosecutions*, 118 A.L.R. FED. 265 (1994).

As one of the responses to public pressure surrounding the use of the insanity defense in the prosecution of John Hinckley for the attempted assassination of President Reagan, Congress enacted the Insanity Defense Reform Act of 1984 (18 U.S.C.A. § 17), which toughened the standard for the application of the defense in federal cases.

Id. A poll conducted by ABC shortly after John W. Hinckley Jr.'s trial in 1982 found that 76 percent of those polled believed that justice had not been done in his trial for the attempted assassination of President Ronald Reagan, which resulted in an insanity acquittal. Associated Press, *Hinkley [sic] Acquittal Brings Moves to Change Insanity Defense*, N.Y. TIMES (June 24, 1982), <http://www.nytimes.com/1982/06/24/us/hinkley-acquittal-brings-moves-to-change-insanity-defense.html>.

insanity defense. Unlike situations in which the ingestion of drugs or alcohol exacerbated a defendant's mental illness, Congress did not consider medication noncompliance at all when it passed the IDRA.²²³ Thus, precluding the insanity defense for the medically noncompliant offender would not be simple statutory interpretation, but would be judge-made law in an area that Congress governs by statute.²²⁴ This would not only violate the separation of powers doctrine, but would also take the judiciary outside of its institutional competency by forcing it to craft a rule that it has neither the expertise nor flexibility to adequately create.²²⁵ Finally, crafting such a rule would be motivated by moral intuitions more properly considered by Congress than by federal courts.²²⁶

In lieu of a statutory response, federal courts should simply rely on a traditional application of the insanity defense²²⁷ and defer to the legislature for any future modifications of the defense.²²⁸ When the insanity defense's traditional reasoning is applied to the medically noncompliant offender, medication noncompliance is irrelevant to an insanity defense's analysis.²²⁹ This outcome reflects the traditional role of the judiciary in interpreting criminal law, which is to interpret and apply the law as it has been enacted by Congress.²³⁰

As shown by *Shin*,²³¹ it is difficult for courts to adequately distinguish between insanity enhanced by medication noncompliance and insanity enhanced by voluntary intoxication.²³² Any judicial foray into this issue claims a power for the judiciary which more properly belongs to the legislature,²³³ even if the judiciary ultimately rejects the argument to prohibit the medically noncompliant offender's insanity defense.²³⁴ Moreover, even in rejecting the argument that medication noncompliance should preclude a defendant from obtaining a "not guilty by reason of insanity" verdict, a court's reasoning through this

²²³ See *supra* Section IV.A.

²²⁴ See *supra* Section IV.A.

²²⁵ See *supra* Section IV.B.

²²⁶ See *supra* Section IV.C.

²²⁷ See *supra* Part III.

²²⁸ See *supra* Part IV.

²²⁹ See *supra* Part III.

²³⁰ See *supra* Part IV.

²³¹ See *supra* Part II.

²³² See *supra* Part II.

²³³ See *supra* Part IV.

²³⁴ In other words, by considering and ultimately rejecting the relevance of the defendant's medication noncompliance to his insanity defense on the grounds that it is factually distinguishable from voluntary intoxication, the court implicitly grants that it could have ruled otherwise and instead chose not to. By instead deferring to the legislature based upon separation of powers principles, the court makes clear that only the legislature has the power to come to a contrary ruling.

issue is liable to create confusing statements, inconsistencies, and contradictions to be exploited in future cases.²³⁵ In any event, the judicial ability to formulate a rule may not be nuanced enough to create a fair and readily applicable law to apply in all noncompliance cases.²³⁶ Thus, considering the merits of this argument—even while ultimately denying its conclusion—may create the opportunity to undermine this outcome in later cases.²³⁷

Congress may see fit to treat the medically noncompliant offender differently in the future.²³⁸ When that occurs, the congresspeople who enacted the law will be held politically responsible at the polls for effecting such a change.²³⁹ These congresspeople would also be more likely than the federal judiciary to have sufficient information and flexibility to craft a nuanced response to this complicated issue.²⁴⁰ Thus, the most appropriate response in light of the complexity of medication noncompliance and the constitutionally mandated principle of separation of powers is for federal courts to hold that the insanity defense applies without restriction in medication noncompliance cases because the federal judiciary is constitutionally incapable and pragmatically ill-equipped to create an exception to the insanity defense when the defendant fails to take his prescribed antipsychotic medication.

CONCLUSION

Serving as a federal judge is difficult enough without having to keep pace with a myriad of rapidly evolving scientific fields.²⁴¹ In particular, the treatment of psychiatric diseases has become an increasingly complicated field as treatment methods have changed and improved significantly over the past three decades.²⁴² A judicial foray into the similarities and differences between medication noncompliance and voluntary intoxication is liable to create more headaches than it

²³⁵ See *supra* Part II and III.

²³⁶ See *supra* Section IV.B.

²³⁷ See *supra* Part II.

²³⁸ Congress has already changed the federal insanity defense by enacting the Insanity Defense Reform Act of 1984, 18 U.S.C. § 17 (2012), and is of course free to continue to do so through subsequent legislation. Whether Congress should enact such a rule, however, is beyond the scope of this Note.

²³⁹ See *supra* Section IV.C.

²⁴⁰ See *supra* Section IV.B.

²⁴¹ As noted by Judge Koszinski, judicial scrutiny of scientific methods and expert testimony can be a “daunting” and “heady task” for federal judges. *Daubert v. Merrell Dow Pharms., Inc.*, 43 F.3d 1311, 1315–16 (9th Cir. 1995).

²⁴² See *Torry & Weiss, supra* note 16, at 221–22.

cures.²⁴³ Instead, federal judges should defer to Congress, which in theory has the expertise, flexibility, and moral authority to concoct a suitable remedy.²⁴⁴ Whether this treatment may be prescribed in all states is beyond the scope of this Note—for example, this approach may not be suitable in jurisdictions in which the insanity defense is governed by case law instead of statute.²⁴⁵ Nevertheless, by deferring to the legislature, at least federal courts will refrain from inducing a bout of doctrinal insanity.

²⁴³ See *supra* Part II.

²⁴⁴ See *supra* Part IV.

²⁴⁵ Massachusetts—the State in which *Shin* was decided—notably falls into this category. See *Commonwealth v. Shin*, 16 N.E.3d 1122, 1123, 1127 (Mass. App. Ct. 2014).