

The *Mickey Finn** Defense: Involuntary Intoxication and Insanity

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The legal context of voluntary and involuntary intoxication is delineated. The author reports a case of involuntary intoxication involving scopolamine toxic psychosis or delirium, in which he testified as a psychiatric expert witness. The specific psychological and physiological symptomatology produced by scopolamine intoxication is outlined. The forensic psychiatrist should be alert to the involuntary intoxication defense in these cases and should familiarize himself with the specific toxicity of scopolamine, in view of the significant increase in the number of incidents in which it is utilized as "knockout" drops in certain jurisdictions.

Hot as a hare, blind as a bat, dry as a bone,
red as a beet, mad as a hatter." [classical description of scopolamine poisoning]²

It is a generally accepted rule of law that a defendant who is *voluntarily* under the influence of intoxicating substances at the time a criminal act is committed will not be relieved of criminal responsibility. "Simply stated, a voluntary intoxication or a voluntary drugged condition does not raise the defense of insanity, but. . . may be used to negate the existence of the mental state which is an element of the crime. A voluntary intoxication or voluntary

drugged condition precludes the use of the insanity defense[†]. . ."³ While failing as a "complete defense" to eliminate culpability entirely, voluntary intoxication nonetheless may be used as evidence to mitigate the seriousness of the offense by negating an element of the crime charged. Thus, for example, a defendant charged with murder may be found guilty of the lesser included crime of manslaughter, if the factfinder determines he was too intoxicated to form the requisite specific intent to cause death (i.e., the intoxication rendered the defendant incapable of forming the specific intent constituting an element of the crime).⁴

In contrast to voluntary intoxication,

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*A drink of drugged liquor; a drink spiked with knockout drops.

†An exception to this rule may exist in the case of voluntary intoxication leading to a settled or fixed permanent type of insanity (e.g., alcoholic psychosis) or resulting in unforeseen temporary insanity (e.g., the LSD cases).

involuntary intoxication is a “complete defense” to a criminal charge. Generally, the defendant must prove three elements:⁵

- 1) He was intoxicated at the time of the criminal act.
- 2) The intoxication was *involuntarily* created.
- 3) His mental state at the time met the jurisdiction’s test for insanity.

The common law recognized involuntary intoxication if it occurred under any of the following conditions: 1) coercion or duress;⁶ 2) “pathological intoxication”;⁷ 3) prescription by a physician;⁸ 4) resulting from an innocent mistake.⁹ In the latter category, an individual makes an “innocent mistake” of fact, by innocently ingesting a substance without knowledge of the foreseeable intoxicating potential of that substance. The “innocent mistake” can occur with or without the machinations, contrivance, trickery, or connivance of another individual.⁵ The prototype of involuntary intoxication is when the intoxicated state results from another person tricking the individual by slipping a potent intoxicating drug into his drink. The unsuspecting victim is said to have been given “knockout drops” or to have been slipped a “Mickey Finn.”[‡] The pleasing concoction then produces a state of stupefaction or confusion that was unforeseeable to the victim and that sets him up for robbery, sexual assault, or other criminal acts. As far back as 1904, ex-Inspector Elliott, formerly of the Glasgow police force, wrote:

The use of drugs . . . or what is more familiarly known in criminal circles as “knockout” drops

‡A notorious saloon-keeper of Chicago, ca. 1896–1906.

is common enough in most cities. What is known as “knockout” drops is chloral hydrate, and from 15 to 30 grains of it produces a sleep that lasts three hours.¹⁰

Eighty years later, in 1984, the New York City Police Department issued an *Operations Order*¹¹ on the subject of “Use of ‘knockout’ drops in certain crimes.” The operations order described a significant increase in the number of robberies committed in which “knockout” drops were used to render the victim helpless. The perpetrator surreptitiously added the drug to the victim’s drink and eventually, “while the victim is incapacitated. . . removes currency, credit cards, jewelry, and/or other property.”¹¹

Although “knockout” drops were originally considered to be mainly chloral hydrate, the 1984 operations order noted that the police laboratory and medical examiner’s office have identified one of the most commonly used “knockout” drops to be scopolamine hydrobromide, commonly diluted in water, “resulting in a colorless, odorless, and tasteless liquid. Prostitutes have been known to carry the diluted solution in eye dropper bottles and/or small plastic squeeze bottles. . . .”¹¹

In some cases, the intended victim may become delirious and perpetrate an act of violence, with the result that he himself is charged with a criminal offense. Such a case is described in the following case report, which illustrates a recent successful involuntary intoxication defense in New York City involving scopolamine.

Case Report

An off-duty police officer met a few colleagues after work and consumed two beers. Later in the evening, he stopped off at a topless bar, a known underworld haunt, for one more beer. After ordering the drink and taking a few sips, he went to the men's room. He returned to the bar and finished his drink. Within fifteen or twenty minutes, he suddenly felt as though his head was spinning. He felt hot, flushed, and dizzy. His throat was exceedingly dry and he had difficulty swallowing. His heart was beating furiously and his vision was blurred. He remembers staggering back from the bar, feeling that his mouth was burning, and then he blacked out completely. He is amnesic for the events that followed. Other observers in the bar noted that he seemed to be confused and delirious. He staggered and strutted around the bar, shouting (at times incoherently). He yelled that he was a policeman and was going to "take care of troublemakers." He waved his gun in a menacing fashion and pointed it at several patrons, causing them to duck under tables and scramble to safety as best they could. He shot one of the patrons at point-blank range, causing serious injuries, for no rational reason. Then he wandered around the nearly deserted bar for 10 or 15 minutes in a confused and agitated state, apparently unable to find the exit. The police finally arrived and placed him under arrest for attempted murder. Although he appeared to be intoxicated according to police reports, no blood tests or urine screening was carried out for alcohol or drugs after his arrest.

Prior to the incident described above, the officer had an unblemished record, had recently received a promotion, and had no history of psychiatric disorder or substance abuse. The psychiatric expert retained by the defense (the author) concluded that the defendant appeared to have suffered an acute confusional state, most probably a reaction to scopolamine intoxication, in view of the constellation of psychological and physiological symptoms he experienced at the time of the incident. These included confusion, disorientation, amnesia, delirium, agitation and aggressiveness, as well as flushed skin, dry and burning mouth, palpitations, blurred vision, and difficulty focusing. He testified that the specific combination of such symptoms, both psychological and physiological, was pathognomonic for scopolamine intoxication. Because the officer was not taking any prescribed medications containing scopolamine or related substances, and because scopolamine is not usually a drug of choice for abuse, the expert opined that the most likely route of administration involved surreptitious addition of the substance to the unsuspecting officer's drink. The expert's clinical inferences were based on the officer's subjective account and the objective observations of third party witnesses, who confirmed that he had been highly confused, disoriented, and irrational at the time of the incident. The police had carried out a cursory investigation and failed to seek any independent corroboration of the officer's account of the incident. Blood or urine samples were not collected for labora-

tory analysis, and no attempt was made to explore the possibility that his drink had been drugged (e.g., by subjecting his glass to forensic analysis or by identifying the perpetrator who allegedly drugged him [which itself would have constituted a criminal act]).

The prosecution's expert argued that, in the absence of any physical corroboration (e.g., finding scopolamine in the officer's blood or urine), the defense had to rely on the officer's self-serving subjective account of the symptoms he had experienced, which might have been fabricated in order to convey the false impression that he was the victim of scopolamine poisoning, rather than admitting to voluntary intoxication with alcohol. He testified that although scopolamine is readily absorbed from the gastrointestinal tract, the onset of psychiatric symptoms would not have been so immediate, but would have taken 30 to 60 minutes to appear. In New York, a finding of involuntary intoxication is not treated as a variant of the insanity defense, but leads to an outright acquittal. In such a case, the defendant had drugs administered to him against his will or by deception, thereby depriving him "of the ability to act consciously and to exercise his own independent judgment and volition. . . ."¹² Because his conduct was involuntary, he could not be found guilty of a criminal act. As one New York court said on the issue:

... criminal liability requires at the very least a voluntary act.¹³

The jury acquitted the defendant police officer of any criminal wrongdoing,

on the basis of involuntary scopolamine intoxication.

Note on Scopolamine Intoxication

Scopolamine is one of the belladonna alkaloids related to atropine. An anticholinergic drug, it is a primary central nervous system depressant with marked sedative and tranquilizing properties. It dilates the pupils, causes blurred vision, dryness of the skin, accelerated heart action, flushing, dryness and burning of the mouth and throat, and difficulty swallowing.¹⁴ Scopolamine has a well-recognized amnesia-producing quality and induces a transient, memory-erasing effect, which has "led to its use as a preanesthetic medication for surgical and obstetrical procedures"¹⁵ ["twilight sleep"]. Although primarily a sedative-tranquilizing drug, scopolamine may cause a paradoxical delirium in as many as 10 percent of patients premedicated with it in the pre- or postoperative period.¹⁵ A striking effect of large doses is the total amnesia that develops for events that occurred while the individual is under the influence of the drug.¹⁴ For those who are excessively susceptible to scopolamine, alarming toxic symptoms may include "marked disturbances of the intellect, ranging from complete disorientation to an active delirium resembling that encountered in atropine poisoning."¹⁴ Anticholinergic intoxication has been described by Homer in *The Odyssey*, by Omar Khayyam, Henry David Thoreau, and others, with accounts of poisoning causing confusion, stupor, and even death.² The intoxication syndrome induced by anticholiner-

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gic agents has been reported for drugs used to treat colds, allergies, motion sickness, peptic ulcer, ophthalmological conditions, and Parkinson's disease.¹⁶⁻¹⁸

A number of articles have described the anticholinergic intoxication syndrome, scopolamine psychosis, and scopolamine dissociative-delirium.^{15, 19-21}

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