

Intoxication and Settled Insanity: A Finding of Not Guilty by Reason of Insanity

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This article presents a case of first-degree murder for which the defendant was acquitted as not guilty by reason of insanity, based on a defense involving the concept of "settled insanity." The literature on settled insanity is reviewed and discussed in the context of voluntary and involuntary intoxication. Statute and case law from those jurisdictions in which settled insanity is specifically allowed as an acceptable threshold condition for the insanity defense define the concept as a permanent condition resulting from substance abuse, rather than the effects of intoxication, no matter how severe. Also discussed are potential criteria for this defense, including evidence that psychotic symptoms thought to be responsible for the crime were, in some manner, separate and apart from symptoms caused solely by voluntary acute intoxication. Other factors that may assist evaluators in differentiating settled insanity from the effects of acute intoxication are presented. It is recommended that evaluators attempt to determine the timing of the onset of psychotic symptoms in relation to substance abuse, the persistence of such symptoms beyond detoxification, and whether ongoing psychiatric treatment is necessary to ameliorate the symptoms beyond intoxication. In the case described, psychotic symptoms persisted long after acute intoxication and beyond the time when drugs or alcohol were detected in the accused's body, requiring clinical intervention for psychosis. Also, before the crime, the defendant had exhibited significant psychological difficulty. The evaluating clinician must still determine, even when a threshold condition is considered to be present, whether statutory criteria for the insanity defense (for the jurisdiction in which the crime allegedly took place) are met.

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Spiegel and Suskind¹ discuss an 1857 trial in which the defense claimed that the defendant should not be held responsible for murder, because the chloroform that was used on the defendant during surgery before the crime was committed induced insanity. Several physicians testified that chloroform had had a negative effect on the defendant, and the defense won the case. The prosecutor was Abraham Lincoln. The impact of substance use in relation to criminal behavior and case outcome has been before the courts for some time. It is particularly important for today's forensic mental health professionals, given that the correlation of major mental illness with substance abuse and substance dependence disorders is as high as 30 to 50 percent.² While there may be some direction estab-

lished through case law, attorneys and others involved with the legal process often rely on the opinion of the forensic mental health clinician in cases in which a defendant has used a mind-altering substance that could have affected behavior at the time of the alleged crime. This article is intended to discuss the concept of settled insanity as a potential threshold condition for clinicians conducting forensic evaluations to determine whether a defendant may have a viable insanity defense.

The M'Naughten standard for a successful insanity defense requires that as a result of "a defect of reason, from disease of the mind," the defendant did not, at the time of the alleged crime, understand the nature and quality of his or her actions or did not know right from wrong.³ The American Law Institute's criterion for a successful insanity defense requires that the defendant be so affected by mental illness that he could not conform his behavior to the

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requirements of the law.⁴ These standards are well known to practicing forensic mental health professionals as those that form the current foundation for insanity, even as the standards vary from jurisdiction to jurisdiction. Both standards require the presence of a mental disease or defect that caused the defendant to be unable to understand or control his or her actions at the time of the crime. Therefore, whether a defendant was using drugs or alcohol while committing a crime should matter little, if at all, to the question of insanity when the criteria for an insanity defense have not been met.

Federal and state courts provide a wide range of interpretations of whether, and under what circumstances, the effects of substance abuse could constitute the threshold condition necessary for the insanity defense. Interpretation could range from the prohibition of any defense when there is evidence of voluntary intoxication to allowing the insanity defense when voluntary intoxication has resulted in only temporary exacerbation of an existing psychosis. However, if it can be demonstrated that substance use has triggered or exacerbated psychotic symptoms that become distinct and independent of acute intoxication (referred to as settled insanity),⁵ the threshold condition could be met.

In the federal courts, as well as in some state courts, the presence of voluntary intoxication rules out any use of the insanity defense. The United States Congress enacted the Insanity Defense Reform Act in 1984,⁶ which narrowed the definition of insanity that had developed in case law (and shifted the burden of proof to the defense at the “clear and convincing” level). The Senate Judiciary Committee, in discussion of the Act, stated that, “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” (Ref. 6, p 229). The courts have generally not upheld substance-induced psychotic symptoms as providing for an insanity defense when the substance in question had been taken voluntarily.⁷⁻¹⁰ In the murder case of *Downing v. Commonwealth*,¹¹ the defense attempted to make the case that the defendant had become “uncharacteristically aggressive” (Ref. 11, p 3) and later had amnesia for the event due to a “grossly altered state” (Ref. 11, p 3) as a result of intoxication. The court ruled “drunkenness [voluntary] may have even produced temporary insanity during the instance when a crime was committed, and yet it would

afford no excuse” (Ref. 11, p 5). Fingarette and Hasse^{12,13} warn that the term involuntary intoxication (particularly as it relates to a disease model of addiction) is a “confusing pseudosimplification” and “would be a grave error” (Ref. 12, p 193); that is, the disease model can imply that the subject has no control over consumption and is therefore not responsible for addiction-related behavior.

Voluntary intoxication may be considered a “partial” defense¹⁴ when the alleged offense requires a specific intent, or *mens rea*, which the defendant may argue that he could not have possessed due to the effects of intoxication.¹⁵ In most states, defendants are not held responsible for crimes committed under the influence of involuntary intoxication, because they are considered “unconscious” and unable to formulate the *mens rea*, or criminal intent, to commit the offense.¹⁶

In the case of *State v. Bush*,¹⁷ the defendant appealed two first-degree murder charges arising from the killing of his former girlfriend and her boyfriend. He lost the appeal, but the court did record that:

Voluntary drunkenness is generally never an excuse for a crime, but where a defendant is charged with murder, and it appears that the defendant was too drunk to be capable of deliberating and premeditating, in that instant intoxication may reduce murder in the first degree to murder in the second degree, as long as the specific intent did not antedate the intoxication [Ref. 17, p 2].

Such instances of diminished capacity, while possibly providing some relief for the defendant, do not result in an acquittal, unlike a verdict of not guilty by reason of insanity. The forensic mental health clinician should be aware of the important distinction between diminished capacity and an insanity defense (including one based on the threshold condition of settled insanity). Diminished capacity is an argument about the specific act for which the defendant is culpable (e.g., first-degree versus second-degree murder), whereas the insanity defense is an argument that the defendant should not be held culpable at all.

Some jurisdictions, such as Connecticut and the District of Columbia, appear to allow the insanity defense in the context of voluntary intoxication only when the defendant has a well-established mental illness, which would independently account for the mental disease or defect under which the defendant met the requirements for the insanity defense. Connecticut law states that the insanity defense is not available if the mental disease or defect was “proxi-

mately caused” by the voluntary ingestion, inhalation, or injection of intoxicating liquor or any drug or substance.¹⁸

In the Ninth Circuit Court of Appeals decision in *United States v. Burnim*,⁸ Burnim had an organic brain defect, became voluntarily intoxicated, and robbed a bank. The court found that Burnim’s insanity was not due to the organic defect alone but to the combination of the organic brain defect and voluntary intoxication, which meant (to the court) that his insanity was not caused by factors beyond his control, and so he was not entitled to the defense. In *State v. Freitas*,⁹ the Hawaii appellate court listened to an argument that the defendant was so impaired that he was unable to distinguish the wrongfulness of his conduct and to conform his conduct to the requirements of the law, due to a combination of three factors: one of which involved alcohol use, the other two of which were psychological. The court denied this appeal, citing that if alcohol were excluded from consideration, the testifying experts would be unable to say with any medical certainty to what degree the defendant’s capacity would have been impaired. The court reaffirmed this decision in *United States v. Knott*.¹⁹ Knott and his accomplice kidnapped several people, raped victims, and stole property. He contended that his drinking and drug use, in combination with his schizophrenia, caused him to be insane when he committed the crimes. He was convicted but appealed. The court denied the appeal on the basis that Knott would have to show that schizophrenia alone was the cause of his criminal actions. The court also acknowledged that if a person is already insane and drinks alcohol, the (insanity) defense is no longer an option.

In the case of *State v. Wicks*,²⁰ in granting Wicks’ appeal on the grounds of insanity when intoxication was involved, the court found that “the only time that drugs or alcohol may be successfully used for an insanity defense is when the influence of alcohol or drugs triggers an underlying psychotic disorder of a settled nature” (Ref. 20, p 2). Such findings are not novel; in *Gills v. Commonwealth*,²¹ the court stated: “Voluntary drunkenness, where it has not produced permanent insanity, is never an excuse for a crime” (Ref. 21, p 4). However, Slovenko²² states, “The law distinguishes between mental impairment that does not go beyond the period of voluntary intoxication, for which no defense is available, and insanity resulting from long-term use of drugs or alcohol” (Ref. 22,

p 269). Carter-Yamauchi⁵ reports that “a majority of jurisdictions in the United States have recognized a defense to criminal acts where long-term, voluntary use of an intoxicant has caused a fixed or ‘settled insanity’ that is distinct from and independent of the period of intoxication” (Ref. 5, p 48).

In *Hawaii v. Tome*,²³ the defendant, tried on weapons and drug charges, was acquitted by reason of insanity based on the defendant’s having proved by a preponderance of the evidence that either she had schizophrenia that was exacerbated by her chronic use of methamphetamine, or she had a methamphetamine-induced psychotic disorder. The defense contended that either of those could have caused her to lack the substantial capacity to appreciate the wrongfulness of her conduct or conform her conduct to the requirements of the law. The court found that the state had failed to prove that the defendant was substantially impaired exclusively due to intoxication. While the Hawaii laws do not directly address the question of settled insanity, this case seems to support the concept as a viable defense. Carter-Yamauchi reviewed the issue of settled insanity and concluded:

A person who is intoxicated is not insane, because insanity requires a disease of the mind or a mental disease or defect. Thus, an intoxication defense is distinct from a typical insanity defense; however, a defense based on a fixed or settled insanity caused by voluntary intoxication, or “settled insanity” as it is termed, is a “slightly different animal” from the typical insanity defense [Ref. 5, p 47].

California law (Criminal Law § 40) states explicitly that “Settled insanity produced by a long-continued intoxication affects criminal responsibility in the same way as insanity produced by any other cause, but it must be settled insanity, and not merely a temporary mental condition produced by the recent use of intoxicating liquor” (cited in Ref. 24, p 2). In *People v. Kelly*,²⁴ the California Supreme Court reversed the finding of a lower court that the defendant was criminally responsible and directed the lower court to enter a judgment of not guilty by reason of insanity for the defendant, who had a substance-induced psychosis. Ms. Kelly was accused of assault with a deadly weapon with the intent to commit murder when she allegedly stabbed her mother with an array of kitchen knives. The defendant had used mescaline and LSD from 50 to 100 times during the previous three years and had been repeatedly jailed, hospitalized, and treated in substance abuse programs. At the time of

the alleged offense, she had been in custody for nearly a month, was released, and then took one dose of mescaline the day before the offense. Subsequent psychiatric testimony indicated that at the time of the offense, Ms. Kelly was hearing voices. She believed that her parents were devils and that if she did not do something she was going to be killed. Testimony from three mental health professionals essentially agreed that the defendant had personality defects that made her susceptible to the development of psychosis and that the drug abuse was the likely trigger of the psychosis; that her symptoms of mental illness on the day of the offense were not symptoms of intoxication alone; and that she should be considered insane at the time of the offense. (One expert witness opined that Ms. Kelly would have had schizophrenia even if she had never taken drugs.)

The trial court found that Ms. Kelly should be held criminally responsible for her conduct because her insanity was temporary and “was not of a settled and permanent nature, and, in addition, was produced by the voluntary ingestion of hallucinatory drugs” (Ref. 24, p 2). The California Supreme Court, in reversing this finding, indicated that

... insanity need not be permanent to establish a defense. . . . We hold that such a temporary psychosis which was not limited merely to periods of intoxication and which rendered the defendant insane under the M’Naughten test constitutes a settled insanity that is a complete defense to the offenses here charged [Ref. 24, p 2].

The court referred to expert witness testimony that the defendant had experienced a previous period of drug-induced psychosis that had necessitated her spending nearly nine months in the state psychiatric hospital to resolve completely.

Subsequently in *People V. Skinner*,²⁵ the California Supreme Court outlined four criteria for determining settled insanity. The illness must: be fixed and stable, last for a reasonable time, not be solely dependent on the ingestion of or the duration of the effects of the drug, and meet the jurisdiction’s legal definition of insanity. This definition should allow the forensic mental health practitioner to opine that a threshold condition for the insanity defense exists in both the case of a fixed and stable impairment caused by chronic substance abuse and the case of preexisting mental illness, unrelated to substance abuse, but triggered by an instance of voluntary intoxication.

The standard for settled insanity in Virginia, where the authors practice and the case discussed in this article was adjudicated, was described in a Virginia Court of Appeals opinion in 2001²⁶ as follows: “Virginia . . . [follows] the common-law rule that ‘settled insanity’ produced by [voluntary] intoxication does provide a defense to crime” (Ref. 27, p 5). Moreover, an accused must still prove that his or her mental state met the appropriate legal definition of insanity (e.g., the M’Naughten Rule) at the time the offense was committed.²⁸ Some states have statutorily rejected the doctrine of settled insanity (e.g., Colorado, Connecticut, and Delaware). Colorado legislation, taking from *Montana v. Egelhoff*,²⁹ makes the case that settled insanity is not a fundamental principle of justice and that denying it is not in violation of the rulings of the United States Supreme Court.

The settled insanity standard appears to be the least restrictive of the standards used to determine when a defendant who voluntarily ingests mind-altering substances is entitled to use the insanity defense. Determining when it may be submitted to the court that a defendant has met the standard for being found not guilty by reason of insanity can be a complicated process of untangling the effects of mental illness and substance abuse. The evaluator’s job obviously would be easier with a standard clearly defined by a statute. Generally, the goal is to determine that a threshold condition of mental disease or mental defect that is more than simple intoxication is present and that the threshold condition resulted in the defendant’s meeting that jurisdiction’s standard for insanity.

It is important to keep in mind, however, what is not necessary for the evaluator to determine. A specific diagnosis (such as substance-induced psychosis versus intoxication with psychotic symptoms), while sometimes helpful, is not always possible and is not necessary. Establishing a clear timeline for the onset of substance abuse problems and mental illness in those with a dual diagnosis is often impossible. The evaluator would be aided by information that demonstrates that a defendant showed signs of mental illness proximate to the offense before the ingestion of substances. Alternatively, the evaluator may be aided by noting whether the symptoms of the mental illness present at the time of the offense persisted beyond the effects of intoxication (as in *People v. Kelley*²⁴). Either observation would support the find-

ing of a threshold condition, while the absence of either would support a finding that no such threshold condition existed. Rarely are the timelines and facts completely clear to the evaluator, requiring conclusions to be drawn exclusively on the likelihood of the presence of settled insanity.

Case Example

The following is a case³⁰ in which the defendant had ingested substances (at least marijuana and alcohol) and reacted to psychotic symptoms in committing the index crime (murder). A plea of not guilty by reason of insanity was entered and successfully defended. The information provided on this case, inclusive of opinion, was based entirely on the evaluation of the defendant's sanity at the time of the alleged offense,³¹ which was completed at the request of the defendant's attorney and subsequent order of the court. The case is in the public domain³⁰ and was the subject of a published account in the local newspaper.³² Additionally, the defendant's permission to publish details about the case in an article for a professional journal was sought and granted, and the defendant's ability to provide this informed consent was independently evaluated by a psychologist with forensic training who was external to the institution where the defendant was receiving treatment and where both authors were employed. The case study proposal was also reviewed and approved by the Central State Hospital Institutional Review Board, which reviews all proposals for research at the institution.

Background

The defendant was a young, never-married man who, according to his mother's report, was born and met early developmental milestones without complication. At approximately age five he began to exhibit behavioral problems. He subsequently received a diagnosis of attention deficit/hyperactivity disorder (ADHD). He was described as having "feelings of inadequacy" and a self-concept that "he is bad." He reportedly exhibited what appeared to be a tic and "grunting sounds" at age 10. Medications were suggested but not taken. The defendant's parents divorced when he was approximately 13 years of age. They reported that they had had several separations before the divorce, during which times the defendant lived with his mother, father, or grandparents. As a teenager, he participated in counseling and later was

prescribed Vistaril. He reported that in his later teens his life had changed because he "went to church and got the spirit."

The defendant reportedly had dropped out of school. One school report indicated that he "has a very difficult time concentrating and remaining on task, and would often blurt out in class unrelated to the subject or topic being discussed." He was also described as having "language related learning disabilities," although he was reported to be of average intelligence. He had been employed in bricklaying, and before the alleged crime (murder), he was employed as a pipe fitter and welder with his father.

The defendant had a significant history of substance abuse. He reported that he had been using marijuana consistently since the age of 14. He stated that he smoked up to "five blunts a day." He described a blunt as approximately the size of a small cigar. He also indicated that he used alcohol excessively. He reported that he had experimented with cocaine and other drugs in the past. He also reported that because he had acknowledged his drug and alcohol use, he was "saved." Just after the alleged crime, the defendant was prescreened while in jail by an examiner in the local Community Mental Health Program. As the result of the prescreening, the defendant was judged to be in need of emergency psychiatric treatment and was admitted to the Commonwealth of Virginia's maximum-security forensic hospital the day after the alleged crime. His admission was followed by a court order for evaluations of his competency to stand trial and sanity at the time of the alleged offense. He was charged with first-degree murder.

The Defendant's Account of the Offense

The defendant was examined on two different occasions concerning the alleged incident. Evaluation interviews were first conducted approximately one month after the defendant was admitted for treatment, because no order had been received requesting an evaluation until that time. We present excerpts that were judged to be representative of the defendant's account of the alleged crime. The defendant knew the victim primarily through his association with the victim's boyfriend, in whose home the murder took place. The defendant readily admitted to drinking alcohol and smoking marijuana on the day of the crime. The defendant stated, "I was thinking [name of boyfriend of the victim] was my dad. I had

been praying to Mary and God that night and weeks before. I could feel them coming over me. They had been helping me a lot.” The defendant went on to report: Mary and God were talking to me. I knew what I had to do, but I didn’t know if I had to do it to [a third person present] or her [the victim]. I was confused. He [a friend of the victim’s boyfriend] said he had a razor. So, I was scared. I told him [the friend of victim’s boyfriend] and [boyfriend of victim] I wanted to go home. I saw three suns on Christmas day. He had a shotgun beside me in the corner, just sitting there. That’s not the gun I used. I was rocking, scared, put on my shoes, got in my truck, but I didn’t have my keys. I was hearing the voices saying I had to kill her. If I didn’t do it, I didn’t know what would happen. I was scared.

The examiner asked the defendant what voices he had been hearing, and he stated, “Of Mary, God’s mother.” The defendant then reported that the friend of the victim’s boyfriend, “nodded . . . He nodded toward the living room. That gave me the okay to do it. I just did it. Maybe I imagined him doing that. The voice had told me to do it. She was evil. Mary told me she was evil and no good, that she needed to die.”

The defendant then described “Mary” as, “I could see her in the sky. She had a big robe on, a blue robe. I couldn’t see no feet.” The examiner then asked the defendant if he really believed that he actually heard the voice of “Mary,” and he said:

I know I did. I still hear it to this day [one month after alleged crime]. Mary said it was going to be okay. I could see her in the sky. That day, I drank a pint of Early Times and smoked about five bucks worth of marijuana. For some reason, he [the boyfriend of victim] was my dad. I don’t know. I just can’t put it together.

Collateral Accounts of the Alleged Incident

The defendant’s supervisor at work stated that the defendant “was really irate and couldn’t keep a train of thought. For the last week [the week before the crime], he couldn’t keep a thought in his head. All week, he was getting worse.” The defendant’s supervisor went on to say that he had suggested that the defendant obtain medication on the day of the murder. The supervisor had sent him to look for some bolts, and then he observed the defendant down the road “throwing snowballs into the woods.” When he asked the defendant what he was doing, the defendant stated, “He was looking for squirrels to feed his family, like his forefathers did.” Persons who associ-

ated with or knew the defendant described him as, “Always crazy, but we’re use[d] to him,” and “He’s always had something wrong [with him].” One person reported that the defendant, just before the alleged crime, had killed a fox and was spreading its blood all over a friend’s porch. Others reported that the defendant appeared to be seeing things that were not there, and still another report indicated that just subsequent to the alleged crime, while in jail, the defendant was “hallucinating, not in his right mind” and that he was hearing command hallucinations. Reportedly, “[the defendant] described himself as, John Smith” and that “while driving on the way to the crime scene [he] believed that there were people along side of the road standing and waving and bowing to him and that a parade of people were following him down the road.” There were also indications that he reported that he was “The son of an Indian chief from the Nottoway River” and that nonrelated persons were members of his family.

The examiner from the local mental health program who screened the defendant for psychiatric admission the day after the alleged crime (while in jail) described the defendant as, “Presented as psychotic. Symptoms include disorientation, confusion, bizarre behavior, banging his head, responding to internal stimulus, and psychomotor agitation.” He was also described as having problems focusing and was given a diagnosis of paranoid schizophrenia with a Global Assessment of Functioning score of 15. (A score of 0 represents extremely poor functioning, and 100 represents superior functioning in a wide range of activities.) On admission to the state hospital the day after the alleged crime, the defendant spoke about “a young girl living with my dad, taking everything he had. (Apparently he had mistaken the victim for this ‘young girl’ and the victim’s boyfriend for his father.)” Subsequent to hospitalization, the defendant continued to exhibit psychotic symptoms. He was reportedly having auditory hallucinations. He continued to describe the victim as “the girlfriend of his father.”

Hospital staff observed the defendant for more than two months after the alleged crime. During this extended observation, the effects of acute intoxication should have worn off, so that the defendant could be assessed for ongoing symptoms of mental illness. The defendant underwent a drug screening the day after admission, which was positive for marijuana but negative for other drugs. Three days later,

he underwent another drug screening with the same results. He continued to exhibit psychotic symptoms. He was described as still “very agitated and reporting voices and paranoid ideation.” The defendant was given Haldol intramuscularly. Approximately two weeks after admission, he was described as “disorganized and exhibiting bizarre behavior. Haldol and Benadryl were given.” Three weeks after the alleged crime, he was described as “agitated and delusional.” More antipsychotic medication was administered. Notes from the hospital staff stated that the defendant had been exhibiting auditory hallucinations, along with thought blockage. He was highly suspicious of having blood drawn and would pace and sing loudly. The defendant was also described as “[believing] that another patient is his grandfather and is hearing voices.” Nursing notes subsequent to this indicated that the defendant was “voicing paranoid delusions and was agitated this morning.” While some improvement was reported in terms of the defendant’s level of agitation, he continued to exhibit auditory hallucinations and paranoid delusions as well as the belief that other patients were members of his family. These psychotic symptoms continued for almost two months after the alleged crime and required clinical intervention (including antipsychotic medication).

Opinion Concerning Sanity at the Time of the Crime

The defendant at the time of the alleged crime appeared to be having a psychotic episode. He exhibited hallucinations, delusions, and thought disorganization. Drug involvement over time could have contributed to a deteriorating, fragile mental condition. The defendant experienced what appeared to be predisposing factors for future psychological problems, including problems in childhood (e.g., a learning disability, attention difficulties, tics, a negative self-perception, and familial dysfunction).

Witnesses who had contact with the defendant during the week before and on the day of the alleged offense indicated he was experiencing significant psychological difficulty. He misidentified individuals, believing they were related to him when in reality they were not. He exhibited hallucinations and believed things were happening which, per the report of others, were not. His supervisor reported that his behavior was “erratic and [he] couldn’t keep a train of thought.”

Just after the crime, the defendant’s behavior seemed atypical for someone who would have understood the nature and consequences of his actions. He made no real attempt to escape. He ran into the woods, placing his cap over his head with his fingers in his ears and sat rocking until the police arrived. He offered no resistance. He continued to exhibit psychotic symptoms of an unusual and bizarre nature, with consistent themes relevant to “Mary” and additional bizarre delusions concerning the identities of different persons in his life (e.g., his father). Interviews subsequent to the alleged crime revealed, as mentioned earlier, that the defendant erroneously believed that the boyfriend of the victim was his father. His logic appeared confused and disjointed. On the way to the crime scene, he believed that people were clapping and bowing to him as he went by. It appeared the defendant believed that he had been exalted to some special status. He appeared naively distant from the gravity of what he had just done, which suggested that he did not recognize the wrongfulness of his actions. After admission to the hospital, the defendant continued to believe that he still heard the “voice of Mary” and had seen her. He exhibited confusion relevant to the identity of others. He also continued to exhibit signs of paranoia and was described as responding to internal stimuli. These symptoms persisted over six weeks after the alleged crime and over six weeks after the last time the defendant had used marijuana, well beyond the generally accepted length of time for marijuana intoxication. Approximately two months subsequent to the alleged crime, the defendant appeared to be developing some insight, although he continued to exhibit confusion regarding reality. The examiner concluded that the defendant was experiencing symptoms of psychosis at the time of the alleged crime that caused him not to know right from wrong and he was therefore insane. The examiner also believed the defendant’s behavior at the time of the alleged crime was the result of a psychosis such as schizophreniform disorder; psychotic disorder, not otherwise specified; substance-induced psychotic disorder with hallucinations and delusions, with onset during intoxication; or possibly, schizophrenia.

Discussion

The opinion that the defendant in the case was insane at the time of the offense was largely based on a clinical presentation that involved the persistence

of psychotic symptoms well beyond that which would be expected for the period of intoxication alone and that required intense clinical attention. The defendant exhibited clear psychotic symptoms long after the drug or alcohol would have been depleted from the body and the acute effects had worn off. Some of these symptoms (hallucinations) are reportedly rare with cannabis use in individuals with stable personalities.³³ It is possible that the defendant had a preexisting emerging psychotic process that may have been triggered by the use of substances. He had exhibited psychological problems in childhood and adolescence. The triggering of psychotic episodes has been described in persons who are vulnerable or have a predisposition for psychosis or have a preexisting psychotic disorder.³⁴⁻⁴⁰ While alcohol consumption has been linked to violence, cannabis infrequently has been linked to physically aggressive behavior⁴¹; however, cannabis use has been demonstrated to enhance aggression in persons who have a mental illness.⁴² It is also possible that the defendant's psychosis would have emerged without the influence of drugs or alcohol; however, drug use probably, to some degree, contributed to the emergence of the psychotic symptoms. Whether these symptoms were triggered by substance use or developed simultaneously but separately from ingestion, the defendant appeared to meet criteria for a successful insanity defense, and the court agreed.

The challenge for the evaluating clinician is not so much to determine an exact diagnosis or origin of any substance-related psychotic symptoms as it is to determine whether these symptoms are more settled and not just the result of acute intoxication. Once it is determined that a condition of lasting impairment that the court may consider a threshold condition such as settled insanity is probably operative, the evaluator must form an opinion as to whether these symptoms meet statutory criteria for the insanity defense, that is, in what manner did these symptoms of mental illness impair the defendant's ability to know right from wrong or to know the nature and consequence of the crime or to resist the impulse to act at the time of the alleged crime. Simply becoming aggressive and having no memory (blackouts) of the crime as the result of the effects of drugs or alcohol, should not, by themselves, support an insanity defense. Becoming enraged or "uncharacteristically aggressive" (Ref. 11, p 5) as the result of acute intoxication has been viewed by the courts as providing no

excuse for criminal behavior. Also, it is possible for a person to have a psychotic reaction to drug use with psychotic symptoms that are unrelated to the behavior involved in the crime or related in such a manner that an insanity defense is not supported.

Voluntary intoxication resulting in acute psychotic symptoms has not generally been a viable defense, even in those cases for which the basic criteria for an insanity defense have been met.^{7-9,11} For example, one may become intoxicated with a resulting delusion (such as believing that one will be killed by aliens) and act on these delusions, committing murder. If these delusions are no longer present once the effects of alcohol have worn off, this situation would not be likely to result in an acquittal as not criminally responsible (except if ingestion had been involuntary). However, as psychosis persists and becomes more settled, the courts have been more likely to hand down a finding of insanity.^{5,23,24,43} Meloy⁴³ reviews the concept of settled insanity as a viable defense, even if the substance was voluntarily ingested. Unfortunately, there is no uniform standard for settled insanity that provides clear direction in these cases. It may be difficult, if not impossible, to determine whether the psychosis was induced or released; in other words, did the drug cause the psychosis or did it merely weaken an existing tenuous ego structure, allowing for the breakthrough of a preexisting, underlying psychosis? To differentiate between the two may not matter (at least to the question of insanity) if the psychosis is settled, and the symptoms persist long after the effects of the drug(s) or alcohol should have worn off.

Urinalysis and blood levels can tell us whether specific drugs are still present in the body. For example, traces of cannabis, especially for long-term users, have been found to be present in the system for as long as a month after ingestion.⁴⁴ Therefore, we might expect to see observable symptoms of marijuana intoxication for some time after ingestion. However, the psychological effects of marijuana ingestion (e.g., problems with memory, psychomotor performance, judgment of time, appetite, and perception)^{38,39} and even hallucinations⁴⁵ are relatively short lived⁴⁶—three to four hours—although the drug can be detected in the system for some time subsequent to cessation of symptoms. Therefore, examining whether the drug or alcohol remains in the body may not be the information on which to base decisions about the effects of the drug (symptoms

that could relate to an insanity defense). However, if the drug is no longer in the system and symptoms persist, it seems to support the existence of settled insanity and not just the outcome of acute intoxication. Determining that the drug has left the body seems to provide the court with more accountability placed on the mental illness than on the drug. In the case presented, drug screening indicated that marijuana remained in the defendant's system for several weeks after ingestion. However, when traces of cannabis were no longer detected, and the defendant continued to manifest psychotic symptoms, it provided support for a more settled illness. As indicated, it is possible that the effect(s) of the drug and/or alcohol were such that it weakened ego controls and acted as a catalyst for the emergence of a preexisting psychosis. It is also possible that the relationship between the drug and/or alcohol use and the psychotic symptoms was coincidental. As with the case presented, identifying the exact time between resolution of intoxication and persistence of psychotic symptoms for the purpose of determining a diagnosis may not be necessary. A finding of mental illness sufficient to meet the first prong of the M'Naughten standard (that there be a mental illness) requires only that psychotic symptoms persist to the extent that they can be considered "settled." Also, in the case that we have presented, the defendant reported that he began to hear voices two or three weeks before the index offense, although the nature of alcohol and drug involvement during that period is not clear. That psychotic symptoms were present before the index offense provides additional support for a more persistent form of psychosis.

Drug- or alcohol-induced mental states, when the causal agent is involuntarily ingested (the Mickey Finn defense⁴⁷), have provided for an affirmative insanity defense. However, as we have indicated, when a drug is taken voluntarily and the defendant commits the crime while in a state of acute psychosis and while intoxicated, the courts have been reluctant to acquit as insane at the time of the crime. The rationale may be that the person committing the crime presumably knew what he was doing when the drug was ingested and therefore should be held accountable. In the case example, the defendant admitted to the ingestion of alcohol and marijuana voluntarily. However, the settled nature of the psychosis seemed to negate the potentially condemning effect of voluntary consumption. When psychosis is more set-

tled, the courts have been more willing to view this as something other than just intoxication, even if intoxication was voluntary. Both M'Naughten³ and the American Law Institute,⁴ as part of their criteria for a successful insanity defense, require that the defendant be under the influence of a mental disease or defect at the time of the alleged crime. But neither provide any definition or criteria for "mental disease or defect," and while experts are often asked to provide specific diagnoses, neither test for insanity requires such.²² Specific diagnosis can be helpful to include exclusionary diagnosis (e.g., certain personality disorders).⁴⁸ In our experience, the Diagnostic and Statistical Manual of Mental Health Disorders—Fourth Edition—Text Revision (DSMR-IV-TR)⁴⁶ generally has been accepted by the courts as an authority for this purpose. A diagnosis of substance intoxication, abuse, or dependence does not, by itself, meet the requirement that the subject had experienced a mental illness at the time of the crime. Some form of psychotic disorder or a disorder that produces psychotic symptoms seems necessary. Bonnie⁴⁹ proposed that for a mental illness to meet criteria for the insanity defense, it should include only severe conditions of mental illness that significantly impair a person's ability to perceive reality and that this mental illness should not be attributable primarily to the voluntary ingestion of alcohol or other psychoactive substance. This position has been endorsed by the American Psychiatric Association.⁵⁰ In the case presented, a diagnosis of substance-induced psychotic disorder (cannabis with hallucination and delusions) and/or alcohol with delusions or hallucinations was entertained, given that clear psychotic symptoms (hallucinations and delusions) were present soon after ingestion. However, the symptoms persisted longer and in excess of what would be expected given the type of substances reportedly ingested, and the defendant required intense clinical attention and intervention (including antipsychotic medication) before he showed improvement. These factors are exclusionary criteria for substance-induced psychosis in the DSM-IV-TR. Therefore, the examiner felt that the defendant could have been experiencing a more settled form of psychosis such as schizophreniform disorder; psychotic disorder, not otherwise specified; or, possibly, schizophrenia. This conclusion was supported by predisposing factors and what was described as a "fragile" premorbid psychological state.

The American Academy of Psychiatry and the Law, in its Practice Guideline—Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense,⁵¹ has proposed that having a specific DSM-IV diagnosis is not necessary to meet the mental disease or defect prong of the insanity defense. This examiner did not provide a specific psychiatric diagnosis or substance abuse diagnoses. Instead, several possibilities were proposed with the provision that the defendant was probably experiencing one of them (or minimally, clear psychotic behavior) that caused him not to understand the wrongfulness of his action at the time of the crime. The examiner wanted to convey to the court that the defendant had experienced more than just symptoms associated with acute intoxication. The diagnoses notwithstanding, it is important to keep in mind that the defendant did not understand the wrongfulness of his actions as a result of some mental illness, whether or not a diagnosable substance disorder was operative. Having to determine an exact diagnosis or whether psychotic symptoms were drug related may make the evaluation task more difficult than it has to be. A focus on separating the diagnoses and then attempting to make a connection between drug use (in this case marijuana) and psychotic symptoms could obscure the main point. The important point is that psychotic symptoms, no matter the origin, drove the behavior involved in the crime. Whether these symptoms were drug induced (the origin of the psychosis), drug precipitated (decompensation of preexisting psychosis), or not related to the drug/alcohol use but happened to emerge simultaneously, the relevant finding is that the symptoms of psychosis persisted after the effects of the drug should have dissipated. The idea that a drug produced mental deterioration related to premorbid psychological factors is similar to the court's decision in *Kelly*²⁴ and is supported by precedent case law as in *People v. Skinner*.²⁵ In *Skinner* the court stated: "... settled must mean fixed and stable for a reasonable duration of time and not solely dependent upon the recent injection or ingestion and duration of the effect of the drug..." (Ref. 25, p 12). This definition also appears to satisfy the criterion for settled insanity set forth by Meloy,⁴³ that the symptoms of mental illness persist beyond the duration of drug intoxication.

Clinicians who evaluate defendants for a possible insanity defense when substance use is involved may want to explore, among other areas, the following:

1. What is the standard, if any, in statutory or case law for settled insanity for the jurisdiction in which the defendant is charged? What is the legal definition of insanity at the time of the offense in that jurisdiction?

2. What symptoms did the defendant exhibit at the time of the crime that would meet the criteria for insanity, regardless of diagnosis or origin of psychotic symptoms?

3. What do collateral sources of information (e.g., witness statements; results of blood, breath, and/or urine tests upon arrest; and crime scene information) indicate about the timing and intensity of the substance abuse in relation to the index offense?

4. Did the defendant exhibit psychotic symptoms only during intoxication or did the symptoms seem to persist after the typical time had passed during which the substance is known to be in its active phase?

5. Was there evidence of psychotic symptoms or episodes of mental illness before or at times other than when the defendant was intoxicated during the index offense?

6. Was clinical intervention necessary to alleviate the psychotic symptoms?

7. Was the substance voluntarily or involuntarily ingested?

8. Did the defendant, before the crime, have knowledge that substance use brought on psychotic symptoms?

9. Are the presenting symptoms consistent or inconsistent with those generally associated with the particular ingested substance(s) or with a psychiatric syndrome?

There are no clear and specific criteria across all jurisdictions for the insanity defense, and when substance use is involved, the picture becomes more clouded. While defined legal standards help clarify the responsibility of the examiner, evaluating clinicians tend to follow statutory guidelines as the general principle and use a deductive process in applying them to individual cases. Clinicians, like most individuals involved with the legal process, would like to have available for use clear and accurate criteria for each legal situation that arises. However, general guidelines to apply to specific cases have merit. It would be very difficult, if not impossible, to legislate statutory guidelines that would cover all possible situations. Case law has been more specific and has given clinicians some direction and precedence to

guide their decisions. But case law is not absolute, and the evaluator is still left with the job of interpreting the findings of individual cases as they relate to the insanity statutes. The determination of whether, and in what manner, the effects of drugs or alcohol on behavior at the time of the offense influence legal findings is the responsibility of the courts. However, the evaluating clinician plays a vital role in providing the courts with information to assist in making that decision.

We hope that this example, accompanying information, and discussion will assist evaluating clinicians in the assessment of defendants for whom a substance use-related insanity defense is a consideration.

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