Caffeine-Induced Psychosis and a Review of Statutory Approaches to Involuntary Intoxication

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Caffeine is the most commonly ingested psychoactive substance in the world. Although caffeine-use disorder is not recognized as a formal diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, five disorders related to caffeine use are enumerated therein. An evolving literature suggests that caffeine is one of many licit substances that may cause psychotic symptoms in higher doses. Here, we present a case in which a defendant ingested large quantities of caffeine, which result in transient psychosis and a successful affirmative defense of involuntary intoxication. The purpose of this article is to summarize states' statutory approaches to involuntary intoxication, given that the term is defined variably, if defined at all. Evaluators must be careful to apply jurisdictionally appropriate standards in involuntary intoxication defenses because the bar for this total defense differs across localities.

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In the United States, 85 percent of adults consume at least one caffeinated beverage daily, with coffee, tea, and soda as the primary sources (96%).[1] Energy drinks and edible sources (e.g., chocolate, headache remedies, etc.) account for the remainder. Despite its common use, caffeine carries certain risks, particularly when consumed in large amounts. Underscoring this fact, the Food and Drug Administration (FDA) issued some guidance in April 2018 to warn manufacturers and the public about the risks associated with highly concentrated caffeine contained in bulk packages of dietary supplements.[2] The FDA warned specifically about the sale of large or bulk packages that contained potentially lethal doses of caffeine. The U.S. Department of Health and Human Services considers 400 mg of daily caffeine intake to be the upper limit of healthy eating patterns.[3]

The autonomic and psychological effects of caffeine are well-characterized. Caffeine traverses the blood–brain barrier and produces its psychological effects by multiple mechanisms, most notably via antagonism of the neuromodulator adenosine. In general, adenosine serves as a central nervous system depressant and plays a somnogenic role in the sleep–wake cycle. Additionally, adenosine receptors are intimately linked to dopaminergic transmission in the central nervous system. Blockade of adenosine A2A receptors results in increased dopaminergic signaling at the D2/D3 receptor level.[4] As is the case with many licit and illicit stimulants, increases in dopaminergic transmission are associated clinically with enhanced wakefulness and arousal. D2 receptor blockade has long been established as the primary mechanism by which antipsychotics reduce positive psychotic symptoms.

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Table 1 Case Reports of Caffeine-Induced Mania and Psychosis

Author	Sex	Age, y	Clinical Presentation	Caffeinated Beverage	Estimated Daily Caffeine Intake, mg	Preexisting Psychiatric Diagnosis
Quadri *et al*[9]	Female	17	Mania	Energy drinks	600 × 1 week	None
Krankl and Gitlin[10]	Female	69	Mania	Coffee/cola	840	None
Cruzado *et al*[11]	Female	31	Mania	Energy drinks	1,000–1,810	None
Ogawa and Ueki[12]	Male	43	Mania	Coffee	660–1,320	None
Kunitake *et al*[13]	Male	54	Mania	Coffee	1,300–2,000	Bipolar spectrum
Machado-Vieira *et al*[14]	Male	36	Mania	Energy drinks	300–400	Bipolar spectrum
Tondo and Rudas[15]	Female	50	Mania	Espresso	900–1,500	Bipolar spectrum
Hernandez-Huerta *et al*[16]	Male	18	Psychosis	Energy drinks	480	None
Govil[17]	Male	35	Psychosis	Source unclear	1,600	None
Görgülü *et al*[18]	Male	21	Psychosis	Energy drinks	Unknown	None
Hedges *et al*[19]	Male	47	Psychosis	Coffee	"High intake"	None
Shaul *et al*[20]	Female	18	Psychosis	Diuretic/caffeine pill	4,800	Anorexia nervosa, no history of psychosis
Peng *et al*[21]	Male	49	Psychosis	Coffee	600	Schizophrenia
Menkes[22]	Male	27	Psychosis	Coffee, energy drinks	600–1,305	Schizophrenia
Cerimele *et al*[23]	Male	43	Psychosis	Energy drinks	1,280–1,600	Schizophrenia
Tibrewal and Dhillon[24]	Male	52	Psychosis	Coffee	960–5,000	Schizophrenia
Lucas *et al*[25]	12 male, 1 female	18–36	Psychosis (exacerbation)	Intravenous; double-blind placebo, controlled	10 mg/kg	Schizophrenia

Role of Caffeine in Psychiatric Disorders

Although the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5), does not recognize caffeine-use disorder as an accepted diagnosis, caffeine is one of 10 substances included in the chapter on substance-related and addictive disorders.[5] Five disorders related to caffeine use are specifically enumerated in the DSM-5:

Caffeine intoxication (305.90, F15.929)

Caffeine withdrawal (292.0, F15.93)

Unspecified caffeine-related disorder (292.9, F15.99)

Caffeine-induced anxiety disorder (292.89, F15.180, 280, and 980)

Caffeine-induced sleep disorder (292.85, F15.182, 282, and 982)

Of these disorders, caffeine intoxication is the most relevant to the current discussion. The DSM-5 defines such intoxication as a "recent consumption of caffeine (typically a high dose well in excess of 250 mg)" and involving at least five of 12 specified signs or symptoms during or shortly after caffeine use. The specific criteria enumerated are restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation.

The DSM-5 does not include caffeine among other substances regarded as being psychotomimetic (e.g., cannabis, phencyclidine, methamphetamine, etc.), and neither psychotic nor manic symptoms are explicitly listed among the 12 signs and symptoms of caffeine intoxication.

Although the DSM-5 does not include caffeine among psychotomimetic substances, an evolving literature suggests a relationship between caffeine intake and psychotic and manic symptomatology.[6–8] Numerous case reports suggest that caffeine may exacerbate preexisting psychiatric conditions, as well as precipitate psychotic and manic symptomatology *de novo* (Table 1).[9–25]

Case Vignette

Defense counsel sought an insanity evaluation of a middle-aged female defendant charged with various misdemeanors and low-level felonies. Police reports indicated that the defendant exhibited agitated, disorganized, and frankly psychotic behavior upon apprehension. Subsequent evaluation of the defendant revealed little, if any, relevant psychiatric history. She reported no history consistent with major depressive

disorder, mania, or psychosis prior to the index offenses. Although the defendant endorsed a remote history of marijuana use, she did not meet DSM-5 criteria for a substance use disorder. A standard urine drug screen shortly after arrest was negative. The defendant recalled daily consumption of four or five pots of coffee (each estimated to be approximately 56 ounces) for approximately 96 hours prior to her arrest. She recalled sleeping very little during that period and becoming increasingly irritable and delusional as her excessive caffeine use continued. Although the defendant required brief treatment with an antipsychotic following arrest, she remained symptom-free for approximately two years following the index offense despite no further intervention. Based on the opined diagnosis of caffeine-induced psychosis, a formal plea of involuntary intoxication was entered, and the defendant was later acquitted of all charges.

Statutory Approaches to Intoxication

Common law has long distinguished between voluntary and involuntary intoxication. In the United States, claims of voluntary intoxication are variably allowed in diminished capacity cases, but such claims are uniformly rejected as a basis for an insanity defense in cases where no evidence of preexisting mental illness exists.[26] Involuntary intoxication, by contrast, offers a complete defense to a crime and has gained traction as a legal strategy in recent years.[27] The Model Penal Code[28] provides a useful framework by which voluntary and involuntary intoxication may be practically distinguished. The Model Penal Code defines intoxication as a disturbance of mental or physical capacities due to the ingestion of a substance. Self-induced intoxication is defined therein as an individual knowingly ingesting a substance, the intoxicating effects of which the individual knows or ought to know. The Model Penal Code further outlines circumstances that render intoxication pathological or involuntary, including taking prescription medications pursuant to medical advice, taking substances under circumstances that would otherwise afford a defense (e.g., coercion, duress), and experiencing intoxication that is grossly excessive, given the amount of substance ingested, if the actor is unaware of this specific susceptibility.

Despite the relative clarity offered by the Model Penal Code, the statutory parameters of an involuntary intoxication defense vary based on jurisdiction. Accordingly, we reviewed all 50 state criminal codes in an effort to better understand statutory approaches to involuntary intoxication. Upon review, three general approaches emerged:

> Involuntary intoxication is clearly identified as an acceptable defense.
>
> Involuntary intoxication is not identified as an acceptable defense, but voluntary intoxication is excluded as an acceptable defense.
>
> Intoxication is possibly mentioned but neither voluntary nor involuntary intoxication are explicitly addressed.

Involuntary Intoxication Clearly Identified

When addressing criminal intent, many states clearly identify involuntary intoxication as an acceptable defense to negate criminal responsibility. Within these statutes, there is variability as to how involuntary and voluntary intoxication are defined. For example, some states, such as Delaware, simply define involuntary intoxication as "intoxication which is not voluntary."[29] Similarly unhelpful, the state of Kansas defines involuntary intoxication as intoxication that is "involuntarily produced."[30] Other states provide much clearer guidance, however. In states where criteria are included to define involuntary intoxication, the main elements identified are lack of consent (e.g., coercion) or lack of knowledge regarding the potential for intoxication. Indiana statute includes both elements when defining involuntary intoxication: "(1) without his consent; or (2) when he did not know that the substance might cause intoxication."[31] Other states expand protections to explicitly include substances that are ingested pursuant to medical advice. Colorado provides relatively clear guidance with regard to involuntary intoxication, in that "[a] person is not criminally responsible for his conduct if, by reason of intoxication that is not self-induced at the time he acts, he lacks capacity to conform his conduct to the requirements of the law."[32] This standard is distinct from Colorado's insanity statute,[33] which requires a defendant to lack capacity to distinguish right from wrong or to form a culpable mental state that is an essential element of the crime charged.

Some states do not address involuntary intoxication specifically but do address intoxication secondary to prescribed substances or other lawful substances. For example, Florida statute specifies that

voluntary intoxication is not a defense "except when the consumption, injection, or use of a controlled substance . . . was pursuant to a lawful prescription issued to the defendant by a practitioner . . . ."[34] Similarly, Michigan statute specifies that voluntary and knowing consumption of alcohol, drugs, or controlled substances is not a defense to a crime except when the individual "voluntarily consumed a legally obtained and properly used medication or other substance and did not know and reasonably should not have known that he or she would become intoxicated or impaired."[35] In states with such statutory approaches, it is conceivable that a substance such as caffeine could be considered in an involuntary intoxication defense.

Involuntary Intoxication Not Addressed

Some states specify that voluntary intoxication is excluded as a defense but do not clarify whether involuntary intoxication is an acceptable defense. For example, California clearly defines "voluntary intoxication" and specifies that "[n]o act committed by a person while in a state of voluntary intoxication is less criminal by reason of his or her having been in that condition. Evidence of voluntary intoxication shall not be admitted to negate the capacity to form any mental states for the crimes charged . . . ."[36] Texas statute specifies that "voluntary intoxication does not constitute a defense to the commission of crime."[37] Similarly, Wyoming statute reads that "self-induced intoxication of the defendant is not a defense to a criminal charge . . . ."[38] Evaluators and attorneys operating in these states may need to review relevant case law to address questions pertaining to involuntary intoxication defenses.

Intoxication Not Explicitly Addressed

A third statutory approach emerged in which intoxication may have been mentioned but neither voluntary nor involuntary intoxication are explicitly addressed. In these states, case law may provide guidance on this topic.

Colorado's Statutory Framework

Some states allow attorneys to assert involuntary intoxication as a possible cause of mental disturbance within the framework of the overall insanity defense, while others establish involuntary intoxication as a stand-alone defense, separate and distinct from the insanity defense. Colorado, the state where the case discussed in this article was adjudicated, takes the latter approach in its statutory framework. In states where involuntary intoxication is a legally separate and distinct defense, there will be a body of case law addressing scenarios where such a defense should be asserted instead of an insanity defense. Statutory frameworks articulating the intoxication defense vary from state to state; case law on involuntary intoxication therefore will likewise vary from state to state. This section offers an overview of the case law in Colorado, which has a specific statute articulating involuntary intoxication as a separate and distinct defense from the insanity defense.

Attorneys may struggle to distinguish whether a defendant's behavior was the product of involuntary intoxication versus a qualifying mental illness without a forensic psychiatric evaluation. Likewise, forensic evaluators may struggle to develop an appropriate opinion in states that define these two defenses separately without some knowledge of governing case law. For these reasons, it is important that forensic evaluators understand not only the statutory standard unique to each defense, but also the case law articulating the defense of involuntary intoxication in states where insanity and involuntary intoxication are legally separate and distinct defenses. The dividing line between an insanity and involuntary intoxication defense is the precise origin of the defendant's mental disturbance. Colorado case law articulates important distinctions between the legal opinion standard for the involuntary intoxication defense and the better-known insanity defense in a state that recognizes each defense separately.

The Colorado case law addressing the intersections of insanity and involuntary intoxication make clear that the legal cornerstone of both are the same: a complete defense to a charged crime is available when the actor is without moral culpability because of a mental disturbance out of the actor's control. The language of the separate statutory standards differs, however, in states that recognize insanity and involuntary intoxication as separate and distinct legal defenses. In Colorado, and in states with a similar statutory framework governing insanity and intoxication, evaluators should educate themselves as to the separate statutory standards for finding a defendant not criminally responsible for their conduct due to psychosis or similar mental disturbance. The cause of the qualifying mental disturbance, and the proper defense to assert in court, has been the subject of

subsequent case law. The separate statutory standards for insanity and involuntary intoxication are discussed in the case law below.

The term "involuntary intoxication" does not actually appear in Colorado's statute governing the intoxication defense. Rather, the statute states that "[a] person is not criminally responsible for his conduct if, by reason of intoxication that is not self-induced at the time he acts, he lacks the capacity to conform his conduct to the requirements of the law." It should be noted that this standard differs from the legal insanity standard in Colorado, under which a defendant must be deemed incapable either of distinguishing right from wrong, forming a culpable mental state, or both. Colorado defines self-induced intoxication as "intoxication caused by substances which the defendant knows or ought to know have the tendency to cause intoxication and which he knowingly introduced into his body . . . unless they were introduced pursuant to medical advice or under circumstances that would afford a defense . . . ." The case law below addresses whether certain defendant scenarios should be argued as involuntary intoxication or insanity, and what is self-induced and what is not self-induced (i.e., involuntary).

In *People v. Turner*, 680 P.2d 1290 (1983),[39] Larry Turner was charged with robbery of a motel and asserted the affirmative defense of intoxication. Mr. Turner contended that he had consumed an overdose of a prescribed migraine drug by mistake and, thus, lacked capacity to conform his conduct to the requirements of the law. Mr. Turner testified that, during the 26 hours leading up to the robbery, he had taken approximately 25 tablets containing butalbital, five at a time, despite the prescribed dosage being two tablets every four hours as needed. Mr. Turner acknowledged that even the prescribed dosage could cause him drowsiness; he also testified that he had often exceeded the prescribed dosage, up to 12 tablets in 24 hours, due to the severity of his pain and perceived relief from depression.

On the date of the offense, Mr. Turner was not getting the desired pain relief from the medication and continued to ingest it throughout the day. Mr. Turner testified that he believed the heavier dosage would merely cause him to go to sleep, based on his prior experience with the drug as well as the lack of any medical warning regarding an overdose of the drug. The trial court ruled that Mr. Turner's intoxication fell under the definition of self-induced as a matter of law, and that he should have known such overdose would cause him to become intoxicated. Based on this ruling, Mr. Turner was prohibited by the trial court from asserting the defense of involuntary intoxication or arguing such to a jury. The Colorado Court of Appeals disagreed and held that Mr. Turner should have been allowed to present this evidence to a jury as a matter of law. Specifically, the court held:

> Here, the defendant presented no evidence that the drugs were forced upon him or introduced through trickery, duress, or other circumstances which would afford a defense to a crime. Nor could he claim that the drugs were introduced pursuant to medical advice since he exceeded the prescribed dosage. However, he argues that by presenting evidence that he did not know and had not been warned of the intoxicating effect of the drug he raised the defense of involuntary intoxication, and the trial court's finding that he knew or should have known of the drug's effect was a usurpation of the jury's fact-finding function (Ref. 39, p 1292).

The court in *Turner* made clear that the question of foreseeability is key to the threshold inquiry of whether intoxication can be argued as involuntary. This case would have been concluded much differently had the drug in question contained explicit warnings of intoxication due to overdose. The appellate court in *Turner* cited several cases from other states in adopting the general rule that, when intoxication is caused by an overdose of a prescribed medication, whether such intoxication is involuntary as a matter of law will depend on whether the individual should have known that intoxication would happen.

In *People v. Low*, 732 P2d 622 (Col. 1987),[40] the Supreme Court of Colorado addressed the foreseeability of self-induced intoxication, as well as the distinction between the involuntary intoxication and insanity defenses. The facts of this case bear most directly on the case addressed in this article. Robert Low, who had not had a diagnosed mental illness in the past, consumed an unusually high number of dextromethorphan-based cough drops on the date of the alleged offense. Mr. Low had used these cough drops for some time and had not experienced psychotic side effects, nor did the cough drops label warn of such potential side effects. He began to express paranoid delusions on a camping and hunting trip after ingesting 120 drops within a 24-hour period, accusing one of his friends (whom he later assaulted) of being the devil. The evaluating psychiatrist in the case opined that Mr. Low was not mentally ill at the time of the offense, but was indeed experiencing what was termed "organic delusional

syndrome" or "toxic psychosis" due to ingestion of an excess of dextromethorphan. The psychiatrist opined:

> There seems to be no doubt that the patient was legally insane at the time he committed the act. At that point in time, he literally did not know the difference between right and wrong, and was unable to adhere to the right. This case is as close to duplicating "McNaughten" [sic] as any I have ever seen (Ref. 40 p 625).

Mr. Low opted for a court trial on charges of felony assault. He was acquitted after the judge found him to be temporarily insane and incapable of forming the culpable mental state required for criminal responsibility (the insanity standard). The Colorado Supreme Court disagreed, however, with the basis of Mr. Low's acquittal, ruling that insanity was not the proper standard in this case and therefore could not be the basis for acquittal. Because Mr. Low's psychosis was caused by an unforeseeable effect of a voluntarily ingested substance, the proper defense to assert was that of involuntary intoxication, not insanity. Thus, the proper test was not whether Mr. Low could distinguish right from wrong, but whether he lacked the capacity to conform his conduct to the requirements of the law. Although involuntary intoxication and insanity may involve clinically similar presentations, the *Low* case illustrates how specific state statutes might guide the language that a forensic evaluator uses in a report or while testifying. The *Low* case also makes clear that in Colorado (and likely in other states with a similar statutory framework), a defendant must proceed under an involuntary intoxication affirmative defense if the cause of the mental disturbance was ingestion of substances whose psychotic effects were unforeseen. In such circumstances, a defendant will not be allowed to opt for the insanity affirmative defense instead of the involuntary intoxication affirmative defense as a matter of preference.

Cases involving psychotic episodes are typically referred by attorneys for an insanity evaluation, and if psychosis is present and the insanity standard seems to be met, an evaluator would typically find the accused legally insane. If the case is governed by a statutory framework such as Colorado's, however, then prior to applying a legal standard for criminal responsibility the evaluator should take care to determine the cause of the psychosis. If the cause of the psychosis is ingestion of a substance whose effects could not be anticipated to cause psychosis, then the evaluator should shift the legal analysis to an involuntary intoxication standard instead of an insanity standard when determining capacity to be held legally responsible for criminal conduct. This can be complex if the defendant has both an underlying mental health diagnosis and possible substance-induced acute psychosis that was not directly caused by the mental health disorder. In deciding whether an insanity or involuntary intoxication standard should be applied, focus should remain on the mental state of the defendant at the time of the alleged offense. If the psychosis at the time of the alleged offense was caused by a substance or medication rather than the underlying mental health disorder, then the analysis should shift to whether psychotic effects of the substance or medication in question would be foreseeable.

In *People v. Garcia*, 113 P.3d 775 (Col. 2005),[41] the Colorado Supreme Court addressed the question of whether mental disturbances secondary to insulin-induced hypoglycemia might absolve a defendant of criminal culpability. Steve Garcia's trial attorney supported involuntary intoxication as the trial defense, but the trial court ruled as a matter of law that evidence of his hypoglycemic condition could only be presented as evidence if Mr. Garcia asserted the insanity defense. Evidence of hypoglycemia would have been disallowed by the court if Mr. Garcia proceeded under the involuntary intoxication defense. The higher court ruled that the trial court was incorrect on this question of whether the hypoglycemic condition could be argued under the involuntary intoxication defense instead of the insanity defense. The Colorado Supreme Court held that hypoglycemia, when insulin-induced, could constitute the defense of involuntary intoxication, and evidence of the condition could be introduced at trial under this defense. Mr. Garcia should not have been forced to proceed under the insanity defense, rather he should have been allowed to argue his condition under the involuntary intoxication defense. Most importantly, this case gave rise to the *Garcia* elements, which are based on Colorado's intoxication defense statute but better articulate the standard for asserting the intoxication defense at trial.[32] These requirements are summarized as follows:

> a substance was introduced into a defendant's body;
>
> the substance was "not known to be an intoxicant" or "was taken pursuant to medical advice,"

or the defendant did not know the substance "could act as an intoxicant";

the substance "caused a disturbance of mental or physical capacities"; and

the introduction of the substance "resulted in the defendant's lack of capacity to conform his or her conduct to the requirements of law" (Ref. 41, p 783).

Garcia is a good example of the fine line that separates the two defenses of insanity and involuntary intoxication. Hypoglycemia, not an underlying mental disorder, was determined to be the cause of Mr. Garcia's psychosis. The hypoglycemia in turn was attributed to the administration of insulin, with unforeseen psychotic effects. Because the trial court considered the hypoglycemic condition an essentially organic condition and not a matter of common-sense intoxication, the ruling at the trial level was that Mr. Garcia had to assert an insanity defense and not an involuntary intoxication defense. The Colorado Supreme Court's disagreement with the trial court in *Garcia* is informative when it comes to how discerning an evaluator must be in considering these two separate and distinct defenses, at least in states that structure them as such. In its holding that, if in fact insulin-induced, the hypoglycemic condition that in turn caused the mental disturbance must be asserted under the involuntary intoxication defense and not the insanity defense, the Colorado Supreme Court properly focused on the root cause of the eventual mental disturbance, even though the medical factor of hypoglycemia was the direct cause of the mental disturbance.

Approach to Involuntary Intoxication

It is likely that cases involving involuntary intoxication will be referred initially for sanity or diminished capacity evaluations. Only upon subsequent forensic evaluation may it become apparent that involuntary intoxication might adequately explain a defendant's behavior. Given the sheer number of substances known to cause or exacerbate mania or psychosis, an exhaustive review will not be provided here, but the information included may be particularly relevant to a wide range of cases involving substances not typically regarded as psychotomimetic.

Evaluating psychiatrists should carefully review a defendant's current medications and take care to inquire about any licit or illicit substances that a defendant might have consumed prior to the incident in question. If specific psychotomimetic substances are identified, evaluators should review that substance's physiological effects as well as any literature suggesting a causal nexus to manic or psychotic states. Once an evaluator determines that a psychotomimetic substance might account for a defendant's behavior with regard to an alleged offense, the evaluator should review state-specific statutes so that an opinion may be offered in language consistent with that jurisdiction's laws.

Forensic evaluators will notice similarities between features of caffeine intoxication and other mental disorders, such as schizophrenia, mania, and brief psychotic disorder, among others. As with any substance-induced diagnosis, it is incumbent upon evaluators to educate the court as to why a defendant's behavior is better explained by the ingestion of a given substance than by a psychiatric disorder. The plausibility of a substance-induced disorder may be enhanced by a variety of factors, including the absence of psychiatric symptoms prior to the ingestion of a given substance or the rapid resolution of symptoms upon cessation of use. In the case above, the defense was fortunate to have medical records reflecting that the defendant's urine drug screen was negative for typical illicit intoxicants. Although numerous case reports supported the diagnosis of caffeine-induced psychosis in our case, other substances (particularly newer medications or synthetic intoxicants) may lack a literature base. In such cases, forensic evaluators will need a sound understanding of the mechanisms of action of the specific intoxicant and craft an argument accordingly.

As we have illustrated, multiple states have statutes that specifically define and address involuntary intoxication. Forensic evaluators should offer their opinions in language specific to these statutes. In states with ambiguous statutes, or where case law provides insufficient guidance, forensic evaluators should consult with retaining attorneys or judges for further guidance to determine if an involuntary intoxication defense is allowable.

Summary

Caffeine-induced psychosis is a relatively rare phenomenon, and the purpose of this article is not to suggest otherwise. The vignette described here, the review of the involuntary intoxication statutes, and the sum-

mary of Colorado case law are intended to serve as a reference for forensic evaluators, attorneys, judges, and others seeking to understand relevant factors in cases of suspected involuntary intoxication. In states where clear statutory guidelines or case law exists, it is important that forensic evaluators render opinions consistent with jurisdictional standards. A successful involuntary intoxication defense does not necessarily involve the application of a state's insanity standards in cases where involuntary intoxication can be demonstrated. Colorado's intoxication statutes provide a framework whereby a defendant may achieve a total defense to a crime without meeting the more stringent insanity criteria. It is important that evaluators understand jurisdictional statutes and case law and do not mistakenly conclude an involuntary intoxication defense to be invalid by incorrectly applying insanity standards.

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