No. 05-5966

IN THE

Supreme Court of the United States

ERIC MICHAEL CLARK,

Petitioner,

v.

STATE OF ARIZONA,

Respondent.

On Writ of Certiorari to the Arizona Court of Appeals

BRIEF OF THE TREATMENT ADVOCACY CENTER AS *AMICUS CURIAE* IN SUPPORT OF NEITHER PARTY

MARY ZDANOWICZ
JONATHAN STANLEY
JOHN SNOOK
TREATMENT ADVOCACY CENTER
200 N. Glebe Road, Suite 730
Arlington, VA 22203
(703) 294-6001

DAVID A. KOTLER
Counsel of Record
MEGAN ELIZABETH ZAVIEH
WILLIAM GIBSON
ELLIOT M. GARDNER
DECHERT LLP
P.O. Box 5218
Princeton, NJ 08543-5218
(609) 620-3200

Counsel for Amicus Curiae

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BRIEF OF THE TREATMENT ADVOCACY CENTER AS *AMICUS CURIAE* IN SUPPORT OF NEITHER PARTY

INTEREST OF THE *AMICUS CURIAE*[1]

The Treatment Advocacy Center ("TAC") is a non-profit organization dedicated to eliminating barriers to treatment for individuals with severe mental illnesses, thereby reducing the consequences of non-treatment such as homelessness, arrest, victimization, hospitalization and violence.[2] TAC's mission is largely focused on improving state civil commitment laws, policies and practices. As a result of outdated civil commitment laws, severely mentally ill people too often are left untreated, which studies have shown leads them to commit acts of violence and become criminal defendants. Proper treatment reduces the likelihood of a severely mentally ill person committing an act of violence to that of an individual without such a disorder. TAC therefore advocates for interventions that can provide early and sustained treatment before a person suffering from severe mental illness becomes dangerous or commits an act of violence.

As the Court considers the questions presented for review, TAC submits that the Court should take into ac-

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[1] Letters from the parties consenting to the filing of *amici* briefs have been lodged with the Clerk of the Court. Pursuant to this Court's Rule 37.6, *amicus* states that no counsel for any party authored this brief, in whole or in part, and that no entity or person, aside from *amicus* and its counsel, made any monetary contribution to the preparation or submission of this brief.

[2] In the interest of maintaining its objectivity, the Treatment Advocacy Center does not accept contributions from pharmaceutical companies or affiliated trade organizations.

count the body of recent research into a neurological deficit known as anosognosia. Anosognosia, which is a common symptom of severe mental illness, inhibits a person's ability to perceive that he is ill and needs to obtain treatment, thus increasing the likelihood that he will engage in criminal behavior. Anosognosia thereby directly impacts whether a mentally ill defendant is morally culpable for his actions. TAC urges that the legal and moral issues presented where a criminal defendant is suffering from anosognosia be fully considered by this Court as it decides the questions before it.

SUMMARY OF ARGUMENT

"The contention that an injury can amount to a crime only when inflicted by intention is no provincial or transient notion. It is as universal and persistent in mature systems of law as belief in freedom of the human will and a consequent ability and duty of the normal individual to choose between good and evil." *Morissette v. United States*, 342 U.S. 246, 250–51 (1952) (citation omitted). Put another way, "there could be no greater cruelty than trying, convicting, and punishing a person wholly unable to understand the nature and consequence of his act[.]" *Sinclair v. State*, 132 So. 581, 585 (Miss. 1931) (concurring opinion).[3]

As this Court and many other courts have recognized, it has been well established over the course of Anglo legal history that criminal defendants whose mental incapacity prevented them from appreciating the nature of their behavior should be treated differently by the legal system than defendants who did not suffer from a mental deficit. As such, our system of laws has provided, for centuries, a

[3] The majority in *Sinclair* held that a statute abolishing the insanity defense in homicide cases violated the due process clause of the Mississippi Constitution.

defense to crime in the form of a plea of insanity. This defense seeks to prevent the unjust punishment, and to encourage the necessary treatment, of people who lack the ability to understand their own actions, while at the same time ensuring the safety of society from violent acts committed by the untreated mentally ill.

Research consistently has shown that severely mentally ill persons who receive proper treatment are no more violent than the general public. It therefore greatly serves the interests of both those afflicted and the general public to treat the severely mentally ill before they commit acts of violence. However, before a person can seek treatment for mental illness, that person must be aware of and accept his condition. Research now has shown that a neurological deficit known as anosognosia prevents many of those with the most serious psychiatric conditions from recognizing, and thus treating, their own illnesses. Compounding this problem, state civil commitment laws often hinder the ability of states to override refusal of treatment until that person poses a danger to himself or others.

TAC is concerned that the insanity defense is becoming a scapegoat for problems actually created by unworkable state civil commitment laws. In the growing number of states that have adopted less restrictive commitment standards, earlier treatment has been shown to reduce arrests and the risk of harmful behavior. In states that have not lowered this barrier to treatment, the insanity defense is often a mentally ill defendant's (and society's) last significant, and sometimes only, opportunity to obtain treatment.

In furtherance of its mission to obtain timely treatment for the severely mentally ill, TAC submits that recent medical research concerning anosognosia should be considered by the Court in weighing whether any specific formulation of the insanity defense comports with the Due Proc-

ess Clause of the Fourteenth Amendment to the United States Constitution.[4] This research, which demonstrates that victims of severe mental illness often are unable to recognize their own disease, provides scientific support for the deeply-rooted common law view that the insane are not morally responsible for their antisocial behavior. As the Court weighs whether Arizona's formulation of the insanity defense and its evidentiary exclusion comport with due process, TAC urges the Court to consider that many of the people to whom these rules apply are rendered incapable, by a symptom of their illness, of understanding that they are ill and need treatment.

TAC does not advocate a particular formulation of the insanity defense, nor does it take a position on whether Arizona's laws comport with the Constitution. TAC does advocate that constitutional due process requires that the goals of the insanity defense—to obtain treatment for the severely mentally ill while protecting society—be advanced by the availability in all states of a meaningful insanity defense based upon a defendant's mental incapacity.

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[4] This Court has frequently relied on scientific and sociological data in examining fundamental Constitutional rights. *See e.g., Brown v. Board of Education,* 347 U.S. 483, 493 (1954) (looking to the "effect of segregation itself on public education"); *Atkins v. Virginia,* 536 U.S. 304, 318 (2002) (examining "clinical definitions" of mental retardation to determine if the "deficiencies" of the mentally retarded "diminish their personal culpability"); *Roper v. Simmons,* __ U.S. __, 125 S.Ct. 1183, 1195 (2005) (citing "scientific and sociological studies" to support the proposition that "juvenile offenders cannot with reliability be classified among the worst offenders" due to their lack of maturity).

ARGUMENT

I. IT HAS BEEN RECOGNIZED FOR CENTURIES THAT CRIMINAL DEFENDANTS WHO LACK UNDERSTANDING OF THEIR ACTIONS, AND THEREFORE LACK MORAL CULPABILITY, SHOULD BE TREATED DIFFERENTLY BY THE LEGAL SYSTEM THAN OTHER DEFENDANTS.

This Court has recognized the "belief, long held by this society, that defendants who commit criminal acts that are attributable to . . . emotional and mental problems, may be less culpable than defendants who have no such excuse." *California v. Brown*, 479 U.S. 538, 545 (1987) (O'Connor, J., concurring). State rules and laws regarding burdens of proof and production in the criminal context are "subject to proscription under the Due Process Clause" only when they "offend[] some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Patterson v. New York*, 432 U.S. 197, 201–202 (1977) (citation omitted). Insanity is "a deficiency in will, which excuses the guilt of crimes." William Blackstone, 4 *Commentaries* *25. Few criminal defenses are as firmly rooted in our traditions as the insanity defense.

The English common law has recognized insanity as a bar to criminal culpability for over seven hundred years. *See* Benjamin B. Sendor, *Crime as Communication: An Interpretive Theory of the Insanity Defense and the Mental Elements of Crime*, 74 Geo. L.J. 1371, 1434 (1986). In the thirteenth century, Bracton wrote that "a crime is not committed unless the intention to injure exists, as may be said of a child or a madman." 2 Henry de Bracton, *On the Laws and Customs of England* 384 (S. Thorne trans. 1968). Madmen commit no crimes, he wrote, "since they are without sense and reason . . . ." *Id*. at 424. Throughout the history of the

English common law, the same rule is repeated time and again.[5] Hence, when the House of Lords announced the *M'Naghten* rule in 1843, it merely fine-tuned a centuries-old doctrine. *See M'Naghten's Case*, 8 Eng. Rep. 718 (1843).

The American common law recognized insanity as a bar to criminal culpability both before and following *M'Naghten*. *See United States v. Clarke*, 25 F. Cas. 454 (C.C.D.D.C. 1818) (court instructed jury that if defendant was "in such a state of mental insanity, not produced by the immediate effect of intoxicating drink, as not to have been conscious of the moral turpitude of the act, they should find him not guilty"); *United States v. Drew*, 25 F. Cas. 913 (C.C.D. Mass. 1828) (finding defendant not guilty by reason of insanity); *Commonwealth v. Rogers*, 48 Mass. 500, 503 (1844) (holding that defendant should be acquitted if his

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[5] *See* William Lambarde, *Eirenarcha* Cap. 21.218 (London, R. Tottell and C. Barker, 1581) ("If a mad man or a naturall foole, or a lunatike in the time of his lunacie . . . do kil a ma[n], this is no felonious acte, nor anything forfeited by it . . . for they ca[n]not be said to haue any understanding wil."); Edward Coke, *Institutes of the Laws of England* 247b (London, John More, 1629) ("in Criminall Causes, as Felonie, &c. the act and wrong of a mad man shall not be imputed to him, for that in those causes, *Actus not facit reum, nisi mens sit rea*, and he is *Amens (id est) sine mente*, without his minde or discretion; and *Furiosus solo furore punitur*, a mad man is only punished by his madnesse"); Michael Dalton, *The Countrey Justice* 283 (London, R. Atkyns and E. Atkyns, 1666) ("If one that is *Non compos mentis*, or an ideot, kill a man, this is no Felony; for they have not knowledg of good and evil, nor can have a Felonious intent, nor a will or mind to do harm . . . . So it is, if a Lunatick person killeth another during his lunacy, it is no Felony . . . ."); William Blackstone, 4 *Commentaries* *25 ("idiots and lunatics are not chargeable for their own acts, if committed when under these incapacities"); 1 William Hawkins, *A Treatise of the Pleas of the Crown* 1 (London, J. Walthoe, 1716) ("The Guilt of offending against any Law whatsoever, necessarily supposing a wilful Disobedience thereof, can never justly be imputed to those who are either uncapable of understanding it, or of conforming themselves to it[.]").

crime "was the result of the disease and not of a mind capable of choosing; in short, that it was the result of uncontrollable impulse, and not of a person acted upon by motives, and governed by the will"); *People v. Lake*, 12 N.Y. 358 (1855) (discussing expert testimony regarding insanity and citing *M'Naghten*); *United States v. Holmes*, 26 F. Cas. 349, 357–58 (C.C.D. Me. 1858) (citing *M'Naghten* and *Rogers*, and holding that jury charges on insanity were correct); *State v. McCoy*, 34 Mo. 531, 533, 536 (1864) (endorsing the *Rogers* rule). By the time that the Fourteenth Amendment was passed in 1866, the insanity defense had firmly taken root in American law.

Underlying these hundreds of years of jurisprudence is an unwavering belief that the insane act without an understanding and appreciation of the consequences of their behavior. This lack of awareness requires, from a constitutional standpoint, that some provision be made for the severely mentally ill to be treated differently under the criminal law.

II. RECENT SCIENTIFIC FINDINGS ABOUT THE NATURE AND EFFECT OF SEVERE MENTAL ILLNESSES ARE ESSENTIAL IN THE DUE PROCESS CONSIDERATION OF ANY CRIMINAL DEFENSE BASED ON A PERSON'S ABILITY TO COMPREHEND THE NATURE, QUALITY OR WRONGFULNESS OF HIS CONDUCT.

Society today knows more than ever about severe mental illnesses and the unique challenges they present to those afflicted. For example, it is now established that severe mental illnesses, such as schizophrenia, are medical diseases that impair the very organ that is used to make deci-

sions.[6] It is now also known that among the symptoms of these diseases is the neurological deficit anosognosia, which prevents affected individuals from knowing they are ill and thus from obtaining treatment.[7] Anosognosia is a biologically-based inability to appreciate one's own illness. Thus, it differs from denial, which is a psychologically-based coping mechanism common within the non-mentally ill population.[8] Despite the public perception that people with severe mental illnesses are more violent than the general public,[9] empirical evidence only supports this view as to people with untreated severe mental illnesses.[10] Research strongly suggests that

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[6] *See generally* U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, *Mental Health: A Report of the Surgeon General* (1999).

[7] Treatment Advocacy Center, *Impaired Awareness of Illness (Anosognosia): A Major Problem for Individuals with Schizophrenia and Bipolar Disorder*, http://www.psychlaws.org/BriefingPapers/BP14.htm (last visited January 26, 2006).

[8] Xavier Amador & Henry Kronengold, *Understanding and Assessing Insight*, in *Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders* 3, 25 (Xavier Amador and Anthony David, eds. 2004).

[9] Patrick W. Corrigan et al., *Implications of Educating the Public on Mental Illness, Violence, and Stigma*, 55 Psychiatric Services 557 (2004).

[10] An English study of 1,015 forensic patients with severe mental illness ("functional psychosis") reported that the diagnosis of "schizophrenia was most strongly associated with personal violence" and that "more than 75 percent of those with a psychosis were recorded as being driven to offend by their delusions." The authors concluded that "treatment appears as important for public safety as for personal health." Pamela J. Taylor et al., *Mental Disorder and Violence*, 172 Brit. J. Psychiatry 218, 218 (1998). *See also* Stephen J. Bartels et al., *Characteristic Hostility in Schizophrenic Outpatients*, 17 Schizophrenia Bull. 163, 166 (1991); Jeffrey Swanson et al.., *Violence and Severe Mental Disorder in Clinical and Community Populations: The Effects of Psychotic Symptoms, Co-*

people with severe mental illnesses who are being treated are no more violent than the general public.[11] Because anosognosia hinders treatment, it increases the odds that those afflicted will commit acts of violence and become criminal defendants.[12]

Anosognosia can prevent a mentally ill person from comprehending—and thereby treating—his own illness. Lack of treatment is known to increase the risk of this person committing a violent act. Consequently, the moral and legal doctrines of the last several centuries dictate that such a person be afforded a defense based upon his mental and, as society now knows, physical ailment.

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morbidity, and Lack of Treatment, 60 Psychiatry 1, 17 (1997); Jerome A. Yesavage, *Inpatient Violence and the Schizophrenic Patient: An Inverse Correlation Between Danger-Related Events and Neuroleptic Levels*, 17 Biological Psychiatry 1331 (1982); Leta D. Smith, *Medication Refusal and the Rehospitalized Mentally Ill Inmate*, 40 Hosp. and Community Psychiatry 491, 494 (1989).

[11] In a survey in which 42 outpatients with schizophrenia, all of whom were apparently taking antipsychotic medication, were compared to a matched control group of medical patients, no differences in criminal behavior were found between the two groups. Henry T. Chuang et al., *Criminal Behaviour Among Schizophrenics*, 32 Canadian J. Psychiatry 255, 257 (1987). The three-site MacArthur Foundation Study of violence and mental illness reported that discharged psychiatric patients without substance abuse had approximately the same incidence of violent behavior as other individuals living in the same neighborhoods. These patients were followed closely for a year and most were taking their medications. Henry J. Steadman et al., *Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 Archives Gen. Psychiatry 393, 400 (1998).

[12] Hans Schanda, *Psychiatry Reforms and Illegal Behavior of the Severely Mentally Ill*, 365 The Lancet 367 (2005).

A. Anosognosia and Mental Illness

Anosognosia is a neurological deficit that impairs a person's ability to recognize that he is ill even when there is overwhelming evidence of his illness.[13] It has been described as "one of the most eccentric neuropsychological presentations one is likely to encounter,"[14] and as being "singularly difficult, for even the most sensitive observer, to picture the inner state . . . for this is unimaginably remote from anything he himself has ever known."[15] One neurologist described the total absence of concern in the person affected as "nothing less than astounding . . . [including] the lack of concern they show for their overall situation, the lack of emotion

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[13] Etymologically, anosognosia is derived from the Greek *nosos*, "disease," and *gnosis*, "knowledge." It literally means to not know a disease. As commonly used, it means to not know one's own disease and is used interchangeably with such terms as "lack of awareness of illness" and "lack of insight." In psychiatry, anosognosia usually connotes three overlapping dimensions: the failure to recognize that one has a psychiatric disease; the inability to recognize that one's unusual mental events, such as delusions and hallucinations, are pathological; and noncompliance with treatment. Anthony David, *Insight and Psychosis*, 156 Br. J. Psychiatry 798, 805 (1990). Other researchers have added additional dimensions to the use of the term, including failure to perceive the need for treatment, lack of awareness of the benefits of treatment, and lack of awareness of the social consequences of having a psychiatric disorder. *See* Xavier Amador & Regine Anna Seckinger, *The Assessment of Insight: A Methodological Review*, 27 Psychiatric Annals 798 (1997). As used in neurology, anosognosia has been defined as "an impaired ability to recognize the presence or appreciate the severity of deficits in sensory, perceptual, motor, affective, or cognitive functioning." *See* Susan Kotter-Cope & Cameron J. Camp, *Anosognosia in Alzheimer Disease*, 9 Alzheimer Disease Assoc. Disorders 52 (1995).

[14] Antonio R. Damasio, *Descartes' Error: Emotion, Reason, and the Human Brain* 62 (1995).

[15] Oliver Sacks, *The Man Who Mistook His Wife for a Hat* 5 (1998).

they exhibit, the lack of feeling they report when questioned about it."[16]

Research now has shown that patients suffering from severe and untreated mental illness who also suffer from anosognosia are unable to differentiate the false perceptions caused by psychotic symptoms, such as delusions and hallucinations, from reality, and they lack knowledge, awareness or recognition of their disease.[17] As a consequence of not being able to recognize that they are ill, these individuals frequently refuse or fail to seek treatment.[18] Consequently, anosognosia contributes to the increased risk of violence caused by untreated mental illness.[19]

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[16] Damasio, *supra* note 14, at 64. *See also* Edwin A. Weinstein & Robert L. Kahn, *Denial of Illness: Symbolic and Physiological Aspects* 18 (1955) ("Anosognosic patients seemed to maintain a serene faith that they were well which remained firm despite all disbelief by others.").

[17] Xavier Amador & Henry Kronengold, *Understanding and Assessing Insight*, in *Insight and Psychosis* 21, 26 (Xavier Amador and Anthony David, eds. 1998).

[18] "[P]oor insight in schizophrenia is associated with poorer medication compliance, poorer psychosocial functioning, poorer prognosis, increased relapses and hospitalization and poorer treatment outcomes." Robert C. Schwartz, *The Relationship Between Insight, Illness, and Treatment Outcome in Schizophrenia*, 1 Psychiatric Quarterly 19 (1998).

[19] E. Fuller Torrey, *The Relationship of Insight to Violent Behavior and Stigma,* in *Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders* 244 (Xavier Amador & Anthony David eds. 2004); Peter F. Buckley et al., *Insight and its Relationship to Violent Behavior in Patients with Schizophrenia*, 161 Am. J. Psychiatry 1712 (2004); Craig Goodman et al., *Insight into Illness in Schizophrenia*, 46 Comprehensive Psychiatry 284, 287 (2005); Peter F. Buckley et al., *Violent Behavior and Lack of Insight in Schizophrenia* (abstract), 67 Schizophrenia Res. 10 (2004); Julio Bobes et al., *Predictors of Number and Severity of Violence Episodes in a One-Year Follow-Up Schizophrenia Sample*, 60 Schizophrenia Res. 333 (2003).

As is not uncommon with the scientific process, it has taken decades of research for scientists to establish the link between anosognosia, risk of violence, and the untreated mentally ill. In the nineteenth and early twentieth centuries, there were observations made that individuals with what was then simply called "insanity" were often unaware of their own illness, but connection to anosognosia was not then made.[20] By the early twentieth century, psychiatrists occasionally noted lack of insight in psychiatric patients. Emil Kraepelin, for example, in his classic 1919 textbook, observed that "understanding of the disease disappears fairly rapidly as the malady progresses in the overwhelming majority of cases, even where in the beginning it was more or less clearly present."[21]

At the time Kraepelin published his textbook, the writings of Sigmund Freud already were circulating in Europe and the United States. Freud taught that denial was one of the most common and important defense mechanisms

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[20] In 1869, an article in the *American Law Review* noted: "Generally, insane people do not regard themselves as insane and, consequently, can see no reason for their confinement other than the malevolent designs of those who have deprived them of their liberty." Anonymous, *Confinement of the Insane*, 3 Am. Law Rev. 193, 215 (1869). Some psychiatrists of that period even suggested that lack of awareness of one's insanity should be the central criterion for the form of insanity then labeled "moral insanity." For a discussion of this, *see* German E. Berrios, *The History of Mental Symptoms* 242–49, 257–59 (1996). This view was an echo of Thomas Dekker's 1604 play, *The Honest Whore*, in which a character declaims: "That proves you mad because you know it not." Thomas Dekker, *The Honest Whore* act 4 sc. 3 (1604), *available at* http://www.tech.org/~cleary/1hw.html, cited by J. Thomas Dalby, *Elizabethan Madness on London's Stage*, 81 Psychol. Rep. 1331, 1333 (1997).

[21] Emil Kraepelin, *Dementia Praecox and Paraphrenia* 26 (E & S Livingstone ed. 1971) (originally published in 1919). Kraepelin also quotes one of his patients as saying: "Whoever thinks that I am mad, is himself mad." *Id.* at 22.

used by people. As Freud's theories became more widely known, the concept of denial became increasingly influential and was invoked to explain why individuals with schizophrenia and other severe psychiatric disorders did not acknowledge their illnesses. Denial as a psychological defense mechanism continued to be a prominent psychiatric explanatory principle throughout the twentieth century.[22] Thus, in the 1960s and 1970s, when state laws governing the treatment of psychiatric patients were undergoing changes, there was no discussion regarding the possibility that unawareness of one's illness might be a biologically-based symptom of the illness rather than denial. The concept of anosognosia simply did not exist in the corpus of psychiatric writings.

In the early 1990s, anosognosia rapidly ascended to prominence in psychiatric literature. Xavier Amador, a psychologist at Columbia University in New York, and Anthony David, a psychiatrist at the Institute of Psychiatry in London, began studies with their colleagues that have continued to the present.[23] Both groups developed assessment tools that can be used to measure awareness of illness: the Scale to Assess Unawareness of Mental Illness and the Schedule for the Assessment of Insight, respectively.[24] The availability of in-

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[22] *See generally* E. Fuller Torrey, *Freudian Fraud: The Malignant Effect of Freud's Theory on American Thought and Culture* (1999).

[23] *See generally* Amador & Kronengold, *supra* note 17, at 26.

[24] Xavier Amador et al., *Assessment of Insight in Psychosis,* 150 Am. J. Psychiatry 873 (1993); Xavier Amador et al., *Awareness of Illness in Schizophrenia,* 17 Schizophrenia Bull. 113 (1991); Anthony David et al., *The Assessment of Insight in Psychosis,* 161 Br. J. Psychiatry 599 (1992). In addition to these scales, others have also been proposed. Comparison studies have reported a high degree of inter-correlation between the scales. *See* M. Sanz et al., *A Comparative Study of Insight Scales and Their Relationship to Psychopathological and Clinical Variables,* 28 Psychol. Med. 437 (1998).

struments that can be used to measure anosognosia in large groups of patients has advanced this research area rapidly.

B. Anosognosia and Schizophrenia

It was not until the 1980s that anosognosia was clearly linked to mental illness, specifically schizophrenia. Joseph McEvoy, a psychiatrist at the University of Pittsburgh, began investigating the link between lack of awareness of illness and the need for involuntary treatment in individuals with schizophrenia. McEvoy found that "committed patients require coercive hospitalization because they fail to recognize their need for care."[25]

There has been an emerging consensus regarding the percentage of individuals with schizophrenia who have anosognosia. A study carried out by Amador and his colleagues reported that fifty-seven percent of patients with schizophrenia "had moderate to severe unawareness of having a mental disorder."[26] Another study of eighty-seven stable outpatients with schizophrenia found that fifty percent "were rated as having at least a moderate impairment in insight about their illness."[27] Another study directly compared

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[25] Joseph P. McEvoy et al., *Why Must Some Schizophrenic Patients Be Involuntarily Committed? The Role of Insight*, 30 Compr. Psychiatry 13, 16 (1989); Joseph P. McEvoy et al., *Measuring Chronic Schizophrenic Patients' Attitudes Toward Their Illness and Treatment*, 32 Hosp. Community Psychiatry 856 (1981).

[26] Xavier Amador et al., *Awareness of Illness in Schizophrenia and Schizoaffective and Mood Disorders*, 51 Archives Gen. Psychiatry 826, 828–29 (1994).

[27] Faith B. Dickerson et al., *Lack of Insight Among Outpatients with Schizophrenia*, 48 Psychiatric Services 195, 197 (1997). Similarly, the large MacArthur treatment competence study found that approximately half of the individuals with schizophrenia lacked an understanding of their illness and/or an appreciation of the importance of treatment. Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Com-*

patients with schizophrenia to patients with focal neurological disorders, such as strokes and brain tumors, on awareness of their illnesses. Among the patients with schizophrenia, forty-seven percent were unaware of their illness, while among the neurological patients, fifty-seven percent were unaware.[28]

These studies demonstrate that approximately half of all individuals with schizophrenia have moderate to severe impairment in awareness of their illness. Moreover, the studies suggest that this impairment in awareness occurs somewhat more often in individuals whose symptoms of schizophrenia are more severe, but that it is not a direct product of delusions, depression, or other symptoms.[29] Rather, the impairment in awareness of illness seen in individuals with schizophrenia is itself a symptom of the disease and is true anosognosia.[30]

C. Consequences of Anosognosia for the Mentally Ill

It increasingly has been recognized that anosognosia has adverse consequences directly correlated to the refusal of treatment for the patient's underlying illness. Individuals who are unaware of their untreated brain disorder often refuse treatment and are more likely to behave in a manner that endangers themselves and those around them. For individuals with untreated schizophrenia, for example, the conse-

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petence Study: III. Abilities of Patients to Consent to Psychiatric and Medical Treatments, 19 Law & Hum. Behav. 149 (1995).

[28] Xavier Amador et al., *Awareness Deficits in Neurological Disorders and Schizophrenia* (abstract), 24 Schizophrenia Res. 96 (1997).

[29] Alisa R. Mintz et al., *Insight in Schizophrenia: A Meta-Analysis*, 61 Schizophrenia Res. 75, 83 (2003).

[30] Amador & Kronengold, *supra* note 17, at 26.

quences of anosognosia may include noncompliance with medication, relapse, incarceration and violent behavior.

a. ***Noncompliance with Medication***

There are many reasons why people do not take medication that has been prescribed for them. For individuals with schizophrenia, however, the main reason they do not take medication is anosognosia—they simply cannot believe they are sick and therefore they do not believe they need treatment.[31]

Studies have identified lack of awareness of illness as a major determinant of medication noncompliance in individuals with schizophrenia.[32] In one study, individuals who were unaware of their illness were only half as likely to take medication compared to individuals who were aware.[33] In another study, sixty-three percent of psychiatric patients with anosognosia were noncompliant with medications compared to a twenty-four percent noncompliance rate for patients who were aware of their illness.[34]

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[31] R. Kessler et al., *The Prevalence and Correlates of Untreated Serious Mental Illness*, 36 Health Services Res. 987 (2001); Treatment Advocacy Center, *What Percentage of Individuals With Severe Mental Illnesses Are Untreated and Why*, http://www.psychlaws.org /BriefingPapers/BP13.pdf (last visited January 27, 2006).

[32] Joseph P. McEvoy, *The Relationship Between Insight Into Psychosis and Compliance with Medications*, in *Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders* 312 (Xavier Amador and Anthony David, eds. 2004).

[33] Ih Foo Lin et al., *Insight and Adherence to Medication in Chronic Schizophrenics*, 40 J. Clinical Psychiatry 430, 431 (1979).

[34] H. Rittmannsberger et al., *Medication Adherence Among Psychotic Patients Before Admission to Inpatient Treatment*, 55 Psychiatric Services 174, 177 (2004).

b. *Relapse and Incarceration*

Since treatment of mental illness has been shown to drastically reduce episodes of violence, and individuals with schizophrenia who have impaired awareness of illness are less likely to be compliant with helpful medication, it logically follows that those suffering from both mental illness and anosognosia are more likely to be arrested and incarcerated.

Individuals with schizophrenia and other psychiatric disorders who are noncompliant with medication have significantly more frequent and severe relapses compared to individuals who are compliant.[35] A 1998 Department of Justice survey reported that sixteen percent of inmates in the nation's jails and prisons were mentally ill.[36] This includes a growing number of mentally ill repeat offenders, such as Gloria Rodgers, who in 1998 was reported to have had 258 previous arrests and to have been jailed 114 times in the previous four years.[37]

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[35] D.A.W. Johnson et al., *The Discontinuance of Maintenance Neuroleptic Therapy in Chronic Schizophrenic Patients: Drug and Social Consequences*, 67 Acta Psychiatrica Scandanivica 339, 347–48 (1983); *see also* McEvoy et al., *Why Must Some Schizophrenic Patients Be Involuntarily Committed? The Role of Insight*, *supra* note 25, at 16; McEvoy et al., *Measuring Chronic Schizophrenic Patients' Attitudes Toward Their Illness and Treatment*, *supra* note 25.

[36] Paula M. Ditton, Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report, *Mental Health and Treatment of Inmates and Probationers* (1999), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf. Since the nation's jail and prison population now includes more than two million individuals, that would mean that approximately 320,000 inmates are mentally ill.

[37] *Graphic Lesson: Assault Sharpens Debate Over Jailed Mentally Ill*, The Commercial Appeal, A10 (Memphis, TN), Oct. 28, 1998.

To TAC's knowledge, no study has specifically assessed awareness of illness among mentally ill prisoners. There is evidence, however, that such individuals tend to have been noncompliant with medication prior to their arrest.[38] One study of mentally ill individuals who have been arrested found that "two highly significant predictors of arrest were substance abuse . . . and noncompliance with medication."[39]

A study of sixty-five patients with severe psychiatric disorders discharged from an Ohio state psychiatric hospital illustrates the problem. Within six months, thirty-three of the sixty-five individuals had become homeless, and twenty-one of these thirty-three had been arrested and jailed. Most of them had been arrested for misdemeanors, such as threatening and bizarre behaviors. The authors of the report noted that "psychotropic medication had been prescribed upon their discharges from the state hospital, but the respondents failed to take their medication."[40]

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[38] Mark R. Munetez et al., *The Incarceration of Individuals with Severe Mental Disorders*, 37 Community Mental Health J. 361, 366 (2001).

[39] Bentson H. McFarland et al., *Chronic Mental Illness and the Criminal Justice System*, 40 Hosp. Community Psychiatry 718, 720 (1989). Such individuals tend to be arrested for misdemeanors such as disorderly conduct and threatening people. For example, one young man smashed a store window "because he saw a dinosaur jumping out at him," and a young woman refused to pay for her meal in a restaurant because she claimed to be "the reincarnation of Jesus Christ." *See* Gary E. Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 Amer. J. Orthopsychiatry 65, 66 (1980), and Edwin V. Valdiserri et al., *A Study of Offenses Committed by Psychotic Inmates in a County Jail*, 37 Hosp. Community Psychiatry 163, 165 (1986).

[40] John R. Belcher, *Are Jails Replacing the Mental Health System for the Homeless Mentally Ill?*, 24 Community Mental Health J. 185, 192

c. *Violent Behavior*

Violent behavior by individuals with schizophrenia and other severe psychiatric disorders is a tragic consequence of anosognosia. In recent years studies have linked violent behavior directly to impaired awareness of illness. One study, carried out in Ohio, assessed 122 patients with schizophrenia who had committed violent acts and compared them with 111 patients with schizophrenia who had not committed such acts. The violent patients had more symptoms and significantly less awareness of their illness.[41] A second study, carried out in New York, examined causes of behavior in sixty severely mentally ill men who had been charged with violent crimes. The author reported that lack of awareness of illness and medication noncompliance both played significant roles in causing the men's violent behavior.[42] A study carried out in Spain on sixty-three patients with schizophrenia admitted to a psychiatric hospital assessed both their violent behavior and their awareness of illness. The authors reported a statistically significant association between impaired awareness of illness and increased violent acts and concluded that "the single variable that best predicted violence was [impaired] insight into psychotic symptoms."[43]

(1988). Substance abuse was also a major problem among this group and contributed to their homelessness and incarceration.

[41] Lee Friedman et al., *Psychometric Relationships of Insight in Patients with Schizophrenia Who Commit Violent Acts* (abstract), 60 Schizophrenia Res. 81 (2003).

[42] Nelly Alia-Klein, *Violence and Psychosis in Relationship to Insight into Illness and Medication Compliance* (submitted for publication, on file at the Treatment Advocacy Center).

[43] Celso Arango et al., *Violence in Inpatients with Schizophrenia: A Prospective Study,* 25 Schizophrenia Bull. 493, 500 (1999).

There is abundant evidence that medication noncompliance is also linked to increased violent behavior. Anecdotal stories abound and are frequently seen in media accounts of tragedies, *e.g.*, "his daughter was not taking her medication at the time of the slaying."[44] There also are multiple studies showing that individuals with severe psychiatric disorders who are unmedicated or undermedicated are significantly more likely to commit violent acts.[45] Persons suffering from anosognosia are more likely to be noncompliant with medication.[46]

III. A CRIMINAL DEFENSE BASED ON SEVERE MENTAL ILLNESS IS NECESSARY BOTH TO PROTECT SOCIETY AND TO ADDRESS THE TREATMENT NEEDS OF THE MENTALLY ILL.

As set forth herein, anosognosia increases the likelihood that victims of severe mental illness will reject or fail to seek treatment. This problem is exacerbated by antiquated state civil commitment laws that forbid treatment interventions until individuals pose an immediate physical danger to themselves or others. Because untreated severe mental illnesses are closely correlated to an increased risk of violence, anosognosia and these commitment laws operate together to

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[44] *Crofton Woman Found Guilty in Mother's Slaying*, Washington Post, Sept. 28, 1990, at D3; *see also* Jay Apperson, *Woman Not Criminally Liable for Ax Murder of Mother*, Baltimore Sun, Sept. 26, 1990, at 4. *See generally Parents Say Newton Man in Stab Attack Failed to Take Meds*, Boston Herald, Dec. 31, 2005, at 10.

[45] John A. Kasper et al., *Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure*, 154 Am. J. Psychiatry 483, 486, 488 (1997); T. Steinert et al., *How Common Is Violence in Schizophrenia Despite Neuroleptic Treatment?*, 33 Pharmacopsychiatry 98, 100–01 (2000).

[46] McEvoy, *supra* note 32, at 328.

ensure that mental illness will cause some of those it afflicts to engage in criminal behavior.

Some states are reacting to the tragic ramifications of untreated mental illnesses, and consequently anosognosia, by adopting more comprehensive commitment schemes with less restrictive, more flexible standards. New York's improved law, known as Kendra's Law, has resulted in dramatic reductions in incarceration, arrests, homelessness and hospitalizations of the severely mentally ill.[47] Extensive clinical research has found analogous outcomes for reformed commitment laws in numerous states.[48]

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[47] *See* N.Y. Mental Hyg. Law § 9.60 (Consol. 2005). Individuals in the first five years of New York's assisted outpatient treatment ("AOT") program experienced fewer hospitalizations (seventy-seven percent), episodes of homelessness (seventy-four percent), arrests (eighty-three percent), and incarceration (eighty-seven percent), and had improved medication compliance (fifty percent) and participation in substance abuse treatment (sixty-five percent). Fifty-five percent fewer recipients engaged in suicide attempts or physical harm to themselves. Three out of every four of the program participants reported that Kendra's Law had helped them regain control of their lives; four out of five said that AOT helped them to get and stay well. *See* New York State Office of Mental Health, *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment* (2005), *available at* http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf.

[48] *See, e.g.*, Marvin S. Swartz et al., *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?*, 156 Am. J. Psychiatry 1968, 1973 (1999) (hospital admissions reduced by fifty-seven percent when used for at least six months and combined with routine mental health services); Jeffrey Swanson et al., *Involuntary Out-Patient Commitment and Reduction of Violent Behaviour in Persons With Severe Mental Illness*, 176 Brit. J. Psychiatry 224 (2000) (assisted outpatient treatment of six months or more combined with routine outpatient services reduced the incidence of violence in half (twenty-four percent versus forty-eight percent)); Jeffrey Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?*, 28 Crim. Just. & Behav. 156, 182–83 (2001) (same); Virginia A. Hiday et

TAC respectfully submits that reforms such as these, as opposed to unduly limiting—if not completely obliterating—the insanity defense, are the proper method to balance safety concerns of States with the due process rights of the mentally ill.

CONCLUSION

Anosognosia has important consequences for individuals with schizophrenia and other severe psychiatric disorders. Since treatment drastically reduces the likelihood of violence, non-treatment—which often is caused by anosognosia—is a major determinant of violent behavior and has a direct impact on the moral culpability of criminal defendants. This neurologically-based problem must be considered as the Court engages in balancing the due process rights of mentally ill defendants with the rights of States to regulate potentially dangerous behavior. As centuries of common law have taught, punishing those who cannot even recognize their own

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al., *Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness*, 159 Am. J. Psychiatry 1403 (2002); Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 Hosp. and Community Psychiatry 1001, 1003 (1990) (median readmissions decrease from 3.7 to 0.7 per 1,000 days); Virginia A. Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 Int'l J. Law & Psychiatry 215, 229 (1987) (over six months, thirty percent medication refusal versus sixty percent absent orders); Robert A. Van Putten et al., *Involuntary Outpatient Commitment in Arizona: A Retrospective Study*, 39 Hosp. & Community Psychiatry 953, 957 (1988) ("almost no patients" without orders voluntarily maintain treatment in mental health system versus seventy-one percent who do in group with orders); Guido Zanni & Leslie deVeau, *Inpatient Stays Before and After Outpatient Commitment*, 37 Hosp. & Community Psychiatry 941, 942 (1986) (hospital readmissions decrease from 1.81 to 0.95 per year).

illness, without careful consideration of their mental illness, cannot comport with constitutional due process.

Respectfully submitted.

MARY ZDANOWICZ
JONATHAN STANLEY
JOHN SNOOK
TREATMENT ADVOCACY CENTER
200 N. Glebe Road, Suite 730
Arlington, VA 22203
(703) 294-6001

DAVID A. KOTLER
Counsel of Record
MEGAN ELIZABETH ZAVIEH
WILLIAM GIBSON
ELLIOT M. GARDNER
DECHERT LLP
P.O. Box 5218
Princeton, NJ 08543-5218
(609) 620-3200

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