

No. 82-3429

IN THE
United States Court of Appeals
FOR THE FIFTH CIRCUIT

UNITED STATES OF AMERICA,
v. *Appellee,*

ROBERT LYONS,
Appellant.

Appeal from the United States District Court
for the Eastern District of Louisiana

BRIEF OF *AMICUS CURIAE*
AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF APPELLANT

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TABLE OF CONTENTS

	Page
TABLE OF CITATIONS	iii
INTEREST OF <i>AMICUS CURIAE</i>	1
STATEMENT OF THE ISSUES PRESENTED	2
STATEMENT OF THE CASE	3
(i) Proceedings Below	3
(ii) Statement of Facts	3
INTRODUCTION AND SUMMARY OF ARGUMENT	5
ARGUMENT	8
I. The Scientific Evidence Supports Defendant's Contention that the Drugs Prescribed by His Physicians Are Highly Addictive Narcotic Opiates	8
II. Although the Scientific Evidence Does Not Clearly Indicate Whether Drug Addiction Itself Is a Mental Disease or Defect, Evidence of a Defendant's Drug Addiction Should Not Automatically Be Excluded in All Cases	16
A. Physiological Theories Do Not Completely Explain Addiction	16
B. Sociological Theories Do Not Completely Explain Addiction	19
C. Although Psychological Theories Do Not Completely Explain Addiction and Do Not Clearly Indicate Whether Addiction Itself Is a Mental Disease or Defect, They Are the Most Widely Accepted Explanations of Addiction	20
D. Evidence of Addiction May Be Relevant to an Insanity Defense	30

TABLE OF CONTENTS—Continued

	Page
III. The Scientific Evidence Supports Defendant's Argument that Drug Addiction Affects the Capacity to Conform One's Conduct to the Re- quirements of Law	35
CONCLUSION	42

TABLE OF CITATIONS

<i>Cases</i>	<i>Page</i>
<i>Bailey v. United States</i> , 386 F.2d 1 (5th Cir. 1967), <i>cert. denied</i> , 392 U.S. 946 (1968)	4, 29, 43
<i>Berry v. United States</i> , 286 F. Supp. 816 (E.D. Pa. 1968), <i>rev'd on other grounds</i> , 412 F.2d 189 (3d Cir. 1969)	29
<i>Biggs v. United States</i> , 318 F. Supp. 212 (N.D. Fla. 1970)	29
<i>Blake v. United States</i> , 407 F.2d 908 (5th Cir. 1969) (en banc)	5, 34, 35, 42
<i>Brinkley v. United States</i> , 498 F.2d 505 (8th Cir. 1974)	29, 32
<i>Brown v. United States</i> , 331 F.2d 822 (D.C. Cir. 1964) (per curiam)	34
<i>Castle v. United States</i> , 347 F.2d 492 (D.C. Cir. 1964), <i>cert. denied</i> , 381 U.S. 929, 953 (1965)	28, 30, 37
<i>Commonwealth v. Sheehan</i> , 376 Mass. 765, 383 N.E.2d 1115 (1978)	29, 32, 33, 34, 44
<i>Demouchette v. State</i> , 502 S.W.2d 712 (Tex. Crim. App. 1973)	33
<i>Dorsey v. State</i> , 586 S.W.2d 810 (Mo. Ct. App. 1979)	29
<i>Dubs v. State</i> , 2 Md. App. 524, 235 A.2d 764 (1967)	31, 32
<i>Faught v. State</i> , 162 Ind. App. 436, 319 N.E.2d 843 (1974)	32, 35
<i>Faught v. State</i> , 155 Ind. App. 520, 293 N.E.2d 506 (1973)	28, 35
<i>Fidelity Federal Savings & Loan Ass'n v. de la Cuesta</i> , 102 S. Ct. 2266 (1982)	43
<i>Fisher v. State</i> , 54 Del. 542, 182 A.2d 333 (1962)	28, 42
<i>Fitts v. United States</i> , 284 F.2d 108 (10th Cir. 1960)	31, 33
<i>Gaskins v. United States</i> , 410 F.2d 987 (D.C. Cir. 1967)	29, 30, 32, 33, 41
<i>Green v. United States</i> , 383 F.2d 199 (D.C. Cir. 1967), <i>cert. denied</i> , 390 U.S. 961 (1968)	32
<i>Greene v. United States</i> , 352 F.2d 366 (D.C. Cir. 1965) (per curiam)	34

TABLE OF CITATIONS—Continued

	Page
<i>Greenleaf v. State</i> , 7 Md. App. 575, 256 A.2d 552 (1969)	34
<i>Heard v. United States</i> , 348 F.2d 43 (D.C. Cir. 1964) (per curiam)	29, 30, 33, 40, 42
<i>Hightower v. United States</i> , 325 F.2d 616 (D.C. Cir. 1964) (per curiam), cert. denied, 384 U.S. 994 (1966)	28, 30, 37
<i>Hines v. Davidowitz</i> , 312 U.S. 52 (1941)	43
<i>Horton v. United States</i> , 317 F.2d 595 (D.C. Cir. 1963) (per curiam)	34
<i>Hutcherson v. United States</i> , 345 F.2d 964 (D.C. Cir.), cert. denied, 382 U.S. 894 (1965)	32
<i>In re Foss</i> , 10 Cal. 3d 910, 519 P.2d 1073, 112 Cal. Rptr. 649 (1974)	29, 37, 38
<i>Kane v. United States</i> , 399 F.2d 730 (9th Cir. 1968), cert. denied, 393 U.S. 1057 (1969)	33
<i>King v. United States</i> , 372 F.2d 383 (D.C. Cir. 1967)	23
<i>Linder v. United States</i> , 268 U.S. 5 (1925)	29
<i>Loveday v. State</i> , 74 Wis. 2d 503, 247 N.W.2d 116 (1976)	40
<i>Martin v. United States</i> , 327 F. Supp. 126 (W.D. Pa. 1971), aff'd, 463 F.2d 220 (3d Cir. 1972) (per curiam)	29
<i>McLaughlin v. State</i> , 236 Ga. 577, 224 S.E.2d 412 (1976)	34, 42
<i>Millard v. Harris</i> , 406 F.2d 964 (D.C. Cir. 1968) ..	24
<i>Murphy v. State</i> , 265 Ind. 116, 352 N.E.2d 479 (1976)	29
<i>Overholser v. O'Beirne</i> , 302 F.2d 852 (D.C. Cir. 1962)	23
<i>People v. Borrero</i> , 19 N.Y.2d 332, 227 N.E.2d 18, 280 N.Y.S.2d 109 (1967)	32
<i>People v. Jackson</i> , 116 Ill. App. 2d 304, 253 N.E.2d 527 (1969)	32, 42
<i>People v. Jaurequi</i> , 142 Cal. App. 2d 555, 298 P.2d 896 (1956)	37

TABLE OF CITATIONS—Continued

	Page
<i>People v. Kelly</i> , 10 Cal. 3d 565, 516 P.2d 875, 111 Cal. Rptr. 171 (1973)	31, 32
<i>People v. King</i> , 181 Colo. 439, 510 P.2d 333 (1973)	32
<i>People v. Penman</i> , 271 Ill. 82, 110 N.E. 894 (1915) ..	32, 33
<i>People v. Peters</i> , 33 Ill. App. 3d 284, 337 N.E.2d 716 (1975)	32
<i>People v. Wyatt</i> , 22 Cal. App. 3d 671, 99 Cal. Rptr. 674 (1972)	37
<i>Perkins v. United States</i> , 228 F. 408 (4th Cir. 1915)	32, 33
<i>Powell v. Texas</i> , 392 U.S. 514 (1968) (plurality) ..	17, 19, 37, 38, 40
<i>Prather v. Commonwealth</i> , 215 Ky. 714, 287 S.W. 559 (1926)	28, 37, 44
<i>Rivers v. United States</i> , 330 F.2d 841 (D.C. Cir. 1964) (per curiam)	34
<i>Robinson v. California</i> , 370 U.S. 660 (1962)	29, 30, 37, 38
<i>State v. Crayton</i> , 354 S.W.2d 834 (Mo. 1962)	32, 42
<i>State v. Fearon</i> , 283 Minn. 90, 166 N.W.2d 720 (1969)	37, 38
<i>State v. Flores</i> , 82 N.M. 480, 483 P.2d 1320 (N.M. Ct. App. 1971)	28, 42
<i>State v. Gaines</i> , 40 Ohio App. 2d 224, 318 N.E.2d 857 (1974)	32
<i>State v. Gilchrist</i> , 15 Wash. App. 892, 552 P.2d 690 (1976)	37
<i>State v. Gilmore</i> , 242 Or. 463, 410 P.2d 240 (1966)	35
<i>State v. Hall</i> , 214 N.W.2d 205 (Iowa 1974)	33
<i>State v. Maik</i> , 60 N.J. 203, 287 A.2d 715 (1972)	31, 32
<i>State v. Matthews</i> , 20 Or. App. 466, 532 P.2d 250 (1975)	33, 42
<i>State v. Plummer</i> , 117 N.H. 320, 374 A.2d 431 (1977)	28
<i>State v. Shipman</i> , 568 S.W.2d 947 (Mo. Ct. App. 1978)	31, 32

TABLE OF CITATIONS—Continued

	Page
<i>State v. Smith</i> , 219 N.W.2d 655 (Iowa 1974).....	40, 42
<i>State v. Valenzuela</i> , 114 Ariz. 81, 559 P.2d 201 (1977)	32, 33
<i>State v. White</i> , 27 N.J. 158, 142 A.2d 65 (1958) ..	29, 40, 42
<i>Stewart v. United States</i> , 214 F.2d 879 (D.C. Cir. 1954)	23
<i>United States v. Baller</i> , 519 F.2d 463 (4th Cir.), cert. denied, 423 U.S. 1019 (1975)	41
<i>United States v. Bass</i> , 490 F.2d 846 (5th Cir. 1974)	5, 31, 41
<i>United States v. Burnim</i> , 576 F.2d 236 (9th Cir. 1978)	33
<i>United States v. Carter</i> , 436 F.2d 200 (D.C. Cir. 1970) (per curiam)	31, 40
<i>United States v. Coffman</i> , 567 F.2d 960 (10th Cir. 1977)	29, 40
<i>United States v. Collins</i> , 433 F.2d 550 (D.C. Cir. 1970)	41
<i>United States v. Cooper</i> , 465 F.2d 451 (9th Cir. 1973)	31
<i>United States v. Fratus</i> , 530 F.2d 644 (5th Cir.), cert. denied, 429 U.S. 846 (1976)	24
<i>United States v. Freeman</i> , 357 F.2d 606 (2d Cir. 1966)	29, 33
<i>United States v. Hall</i> , 583 F.2d 1288 (5th Cir. 1978)	32
<i>United States v. Harper</i> , 450 F.2d 1032 (5th Cir. 1971)	23
<i>United States v. Ingman</i> , 426 F.2d 973 (9th Cir. 1970)	32
<i>United States v. Kohlman</i> , 469 F.2d 247 (2d Cir. 1972)	23
<i>United States v. Lyons</i> , 704 F.2d 743 (5th Cir. 1983)	5
<i>United States v. Mason</i> , 277 F. Supp. 114 (W.D. Mo. 1967)	34
<i>United States v. McKnight</i> , 427 F.2d 75 (7th Cir.), cert. denied, 400 U.S. 880 (1970)	28

TABLE OF CITATIONS—Continued

	Page
<i>United States v. Moore</i> , 486 F.2d 1139 (D.C. Cir.) (en banc), cert. denied, 414 U.S. 980 (1973)....	5, 40
<i>United States v. O'Neal</i> , 431 F.2d 695 (5th Cir. 1970), cert. denied, 401 U.S. 917 (1971).....	23
<i>United States v. Poolaw</i> , 588 F.2d 103 (5th Cir. 1974).....	29
<i>United States v. Robertson</i> , 507 F.2d 1148 (D.C. Cir. 1974)	23
<i>United States v. Stevens</i> , 461 F.2d 317 (7th Cir.), cert. denied, 409 U.S. 948 (1972)	29
<i>Watson v. United States</i> , 439 F.2d 442 (D.C. Cir. 1970) (en banc)	30, 32, 34, 37, 40

Books and Periodicals

E. ABEL, <i>DRUGS AND BEHAVIOR: A PRIMER IN NEUROPSYCHOPHARMACOLOGY</i> (1974)	9, 10, 11, 12, 14, 37
AMERICAN BAR ASSOCIATION, <i>FIRST TENTATIVE DRAFT OF THE CRIMINAL JUSTICE MENTAL HEALTH STANDARDS</i> (1983)	2
AMERICAN PSYCHIATRIC ASSOCIATION, <i>DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS</i> (3d ed. 1980)	9, 10, 12, 19, 20, 21, 22, 23, 24, 36
Bennett, <i>Drug Addiction and Its Effect on Crim- inal Responsibility</i> , 9 WAKE FOREST L. REV. 179 (1973)	21, 37, 38
Blachly, <i>Theories of Addiction</i> , in <i>DRUG ABUSE Now 192</i> (P. Blachly ed. 1972)	21
Blum, <i>Mind-Altering Drugs and Dangerous Be- havior</i> , in <i>TASK FORCE ON NARCOTICS AND DRUG ABUSE, TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE 40</i> (1967)	8, 13, 15, 17, 19, 20, 39
Bourne, <i>Issues in Addiction</i> , in <i>ADDICTION</i> (P. Bourne ed. 1974)	26
Bowman, <i>Narcotic Addiction and Criminal Respon- sibility Under Durham</i> , 53 GEO. L.J. 1017 (1965)	11, 12, 13, 15, 17, 19, 20, 21, 24, 25, 27, 28, 36, 37, 38, 39, 41, 42

TABLE OF CITATIONS—Continued

	Page
• Case Comment, <i>Criminal Law: Chronic Alcoholism as a Defense to Crime</i> , 61 MINN. L. REV. 901 (1977)	38, 42
Chamblis, <i>Types of Deviance and the Effectiveness of Legal Sanctions</i> , 1967 WIS. L. REV. 703	38
Chayet, <i>Legal Aspects of Drug Abuse</i> , 3 SUFFOLK U.L. REV. 1 (1968)	38
I. CHEIN, D. GERARD, R. LEE, & E. ROSENFELD, <i>THE ROAD TO H</i> (1964)	20, 21, 22, 26
G. CLARIDGE, <i>DRUGS AND HUMAN BEHAVIOR</i> (1970)	26, 27, 28
Comment, <i>Criminal Responsibility and the Drug Dependence Defense—A Need for Judicial Clarification</i> , 42 FORDHAM L. REV. 361 (1973)	29
DeLong, <i>The Drugs and Their Effects</i> , in <i>DEALING WITH DRUG ABUSE: A REPORT TO THE FORD FOUNDATION</i> 62 (1972)	19
Dole, <i>Biochemistry of Addiction</i> , 39 ANN. REV. OF BIOCHEMISTRY 821 (1970)	37
Dole & Nyswander, <i>Methadone Maintenance and Its Implications for Theories of Drug Addiction</i> , in <i>THE ADDICTIVE STATES</i> 359 (A. Wikler ed. 1968)	18
Felix, <i>An Appraisal of the Personality Types of the Addict</i> , 100 AM. J. PSYCHIATRY 462 (1944) ..	21, 37
H. FINGARETTE & A. HASSE, <i>MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY</i> (1979)	12, 13, 15, 17, 19, 23, 27, 28, 38
Francis, <i>Opiate Dependence and Tolerance: A Pharmacological Analysis</i> , in <i>THE BIOCHEMISTRY OF SCHIZOPHRENIA AND ADDICTION</i> 227 (G. Hemmings ed. 1980)	14
Gendreau & Gendreau, <i>A Theoretical Note on Personality Characteristics of Heroin Addicts</i> , 82 J. ABNORMAL PSYCHOLOGY 139 (1973)	27
Gerard & Kornetsky, <i>Adolescent Opiate Addiction: A Study of Control and Addict Subjects</i> , 29 PSYCHIATRIC Q. 457 (1955)	25, 26

TABLE OF CITATIONS—Continued

	Page
Gilbert & Lombardi, <i>Personality Characteristics of Young Male Narcotic Addicts</i> , 31 J. CONSULTING PSYCHOLOGY 536 (1967)	21, 24, 26
A. GOLDSTEIN, L. ARONOW, & S. KALMAN, THE PRINCIPLES OF DRUG ACTION (1969)	19
Hill, Haertzen, & Glaser, <i>Personality Characteristics of Narcotic Addicts as Indicated by the MMPI</i> , 62 J. GENERAL PSYCHOLOGY 127 (1960) ..	20, 21, 22, 26
Isbell & White, <i>Clinical Characteristics of Addiction</i> , 14 AM. J. MED. 558 (1953)	36
Jaffe, <i>Drug Addiction and Drug Abuse</i> , in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 284 (L. Goodman & A. Gilman 5th ed. 1975) ..	11, 12, 13, 14, 15, 17, 19, 21, 27, 39, 44
Jaffe & Martin, <i>Narcotic Analgesics and Antagonists</i> , in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 245 (L. Goodman & A. Gilman 5th ed. 1975)	8, 9, 10, 11, 12, 13
R. JULIEN, A PRIMER OF DRUG ACTION (3d ed. 1981)	8, 9, 10, 11, 12, 13, 15, 37, 39
Khantzian, <i>Opiate Addiction: A Critique of Theory and Some Implications for Treatment</i> , 28 AM. J. PSYCHOTHERAPY 59 (1974)	26
L. KOLB, DRUG ADDICTION: A MEDICAL PROBLEM (1962)	20, 22
Korin, <i>Comparison of Psychometric Measures in Psychiatric Patients Using Heroin and Other Drugs</i> , 83 J. ABNORMAL PSYCHOLOGY 208 (1974)	21
C. KORNETSKY, PHARMACOLOGY: DRUGS AFFECTING BEHAVIOR (1976)	9, 10, 11, 12, 13, 14, 15, 20, 27, 28, 38, 39
W. LAFAVE & A. SCOTT, CRIMINAL LAW (1972) ..	23, 24
R. LEVITT, PSYCHOPHARMACOLOGY: A BIOLOGICAL APPROACH (1975)	8, 10, 11, 12, 13, 14, 16
A. LINDESMITH, ADDICTION AND OPIATES (1968) ..	27

TABLE OF CITATIONS—Continued

	Page
NATIONAL COMMISSION ON MARIJUANA AND DRUG ABUSE, DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE (Second Report, March 1973)	39
A. NOYES & L. KOLB, MODERN CLINICAL PSYCHIATRY (6th ed. 1963).....	21
Nurco, <i>Etiological Aspects of Drug Abuse</i> , in HANDBOOK ON DRUG ABUSE 315 (R. Dupont, A. Goldstein, & J. O'Donnell ed. 1979).....	19, 28
S. PEELE, THE SCIENCE OF EXPERIENCE: A DIRECTION FOR PSYCHOLOGY (1983)	17, 28, 36
PHYSICIANS' DESK REFERENCE (37th ed. 1983) ..	8, 9, 10, 11, 12, 14
O. RAY, DRUGS, SOCIETY, AND HUMAN BEHAVIOR (1972)	9, 12, 13, 17, 27, 36
L. ROBINS, A FOLLOW-UP OF VIETNAM DRUG USERS (Special Action Office Monograph, Special Office for Drug Abuse Prevention, Executive Office of the President, U.S. Gov't Printing Office Series A, No. 1, 1973)	17, 18
L. ROBINS, VETERANS' DRUG USE THREE YEARS AFTER VIETNAM (Report to the National Institute of Drug Abuse 1976)	18
L. ROBINS, THE VIETNAM DRUG USER RETURNS (Special Action Office Monograph, Special Office for Drug Abuse Prevention, Executive Office of the President, U.S. Gov't Printing Office Series A, No. 2, 1974)	18
Robins, <i>Addict Careers</i> , in HANDBOOK ON DRUG ABUSE 325 (R. Dupont, A. Goldstein, & J. O'Donnell ed. 1979)	17, 21, 39
Smart & Jones, <i>Illicit LSD Users: Their Personality Characteristics and Psychopathology</i> , 75 J. ABNORMAL PSYCHOLOGY 286 (1970)	21, 22, 25, 26
Special Project, <i>Drugs and Criminal Responsibility</i> , 33 VAND. L. REV. 1145 (1980)	8, 9, 10, 11, 12, 19, 31, 35, 37, 38, 39
Sutker, <i>Personality Differences and Sociopathy in Heroin Addicts and Nonaddict Prisoners</i> , 78 J. ABNORMAL PSYCHOLOGY 247 (1971)	25

TABLE OF CITATIONS—Continued

	Page
Sutker & Allain, <i>Incarcerated and Street Heroin Addicts: A Personality Comparison</i> , 32 PSYCHOLOGICAL REP. 243 (1973)	22, 24
TASK FORCE ON NARCOTICS AND DRUG ABUSE, TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE (1967)	39
Wikler, <i>Dynamics of Drug Dependence: Implications of a Conditioning Theory for Research and Treatment</i> , in OPIATE ADDICTION: ORIGINS AND TREATMENT 7 (S. Fisher & A. Freedman ed. 1970)	27
Winick, <i>Narcotics Addiction and Its Treatment</i> , 22 LAW & CONTEMP. PROBS. 9 (1957)	13
WORLD HEALTH ORGANIZATION, TECHNICAL REPORT No. 2 (1950)	37
Zinberg, <i>Nonaddictive Opiate Use</i> , in HANDBOOK ON DRUG ABUSE 303 (R. Dupont, A. Goldstein, & J. O'Donnell ed. 1979)	17
Zinberg, <i>Rehabilitation of Heroin Users in Vietnam</i> , 1 CONTEMPORARY DRUG PROBS. 263 (1972) ..	18
 <i>Statutes, Regulations, and Legislative Materials</i>	
H.R. REP. No. 2388, 84th Cong., 2d Sess. (1956)	29
Narcotic Addict Rehabilitation Act of 1966, 28 U.S.C. § 2901 <i>et seq.</i>	38, 43
Rehabilitation Act of 1973, § 7(6), 29 U.S.C. § 706(7)	29
S. REP. No. 1440, 84th Cong., 2d Sess. (1956)	29
S. REP. No. 2033, 84th Cong., 2d Sess. (1956)	38
21 U.S.C. § 2	3
21 U.S.C. § 843(a) (3)	3
34 C.F.R. part 104 App. A (1982)	29

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No. 82-3429

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Appellant.

Appeal from the United States District Court
for the Eastern District of Louisiana

BRIEF OF AMICUS CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF APPELLANT

INTEREST OF AMICUS CURIAE

Pursuant to the Court's invitation, the American Psychological Association (APA) files this brief as *amicus curiae* in support of appellant. The APA is a voluntary nonprofit, scientific, and professional organization with more than 55,000 members. It has been the major association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country. The APA's purpose, as reflected in its bylaws, is to "advance psychology as a science and profession, and as a means of promoting human welfare by the encouragement of psychology in all branches"

A substantial number of the APA's members are involved in the clinical and experimental study of drug dependency, its causes and effects. A corresponding number engage in research regarding the effect of mental disability on behavior. In addition, many professional psychologists serve as forensic experts in criminal trials where the defendant's mental state is at issue. Several APA members with special training and knowledge participated in the production of the American Bar Association's *First Tentative Draft of the Criminal Justice Mental Health Standards* (1983). Many of the Association's substantive divisions are also vitally interested in the matters at issue here. For example, over 1000 members along to the Division of Psychopharmacology and over 600 belong to the Division of Psychology and Law. Most important, the APA is deeply concerned about the prevalence of narcotics addiction in this country. As a result, it encourages research in the etiology and treatment of drug-dependent persons, with the goal of reducing the incidence of addiction.

Thus, this case is of special concern to psychologists and to the APA. The APA is honored to have been invited to present its views on the important questions before the Court, questions on which its expertise and experience can, it trusts, be useful. *Amicus* hopes to provide this Court with a broad-based, empirically oriented perspective in order to help it resolve the complex issues presented by this case.

STATEMENT OF THE ISSUES PRESENTED *

1. Should testimony regarding a criminal defendant's drug addiction, no matter how extreme or advanced, be

* The questions addressed in this brief correspond generally to questions no. 4 and 1, respectively, listed in the Court's invitation to file an *amicus* brief. The APA has chosen to address only the

excluded as evidence relating to the defendant's insanity defense?

2. If evidence regarding a defendant's drug addiction is admissible on the issue of insanity, is such evidence relevant only when the addiction is involuntarily rather than voluntarily acquired?

STATEMENT OF THE CASE

(i) *Proceedings Below.* Defendant, former Sheriff of Washington Parish, Louisiana, was indicted on twelve counts of knowingly and intentionally securing controlled substances by misrepresentation, fraud, deception, and subterfuge, in violation of 21 U.S.C. § 843(a)(3) and 21 U.S.C. § 2. Prior to trial, defendant notified the Government that he intended to rely upon an insanity defense. In response to the Government's motion in limine, the District Court for the Eastern District of Louisiana excluded all evidence of defendant's drug addiction offered in support of an insanity defense. Defendant then submitted a proffer setting forth the specific evidence he would rely upon in establishing his insanity defense.

The District Court adhered to its decision, issuing written reasons for its ruling. Defendant then waived his right to trial by jury, stipulated that the evidence to be offered by the Government would support a finding of guilt, and reoffered his proffer. The District Court found defendant guilty as charged. This appeal followed.

(ii) *Statement of Facts.* According to defendant's proffer, he initially received Percodan and Demerol while

narrower issues involving the admissibility of evidence of drug addiction to support the defense of insanity, rather than the broader ones involving the adoption of a different definition of insanity and the proper allocation of the burden of proof. The Association is now in the process of formulating its views on the definition of insanity and considers questions regarding the burden of proof to be legal rather than scientific.

hospitalized for surgery in August of 1978. His doctors continued to prescribe increasing amounts of these narcotics, as well as Mepergan and Talwin tablets, for various physical ailments through the end of 1980.

Beginning in October 1978 and at various times through the middle of August 1981, defendant followed the suggestion of one of his physicians, Dr. Glenn Hebert, and secured prescriptions for narcotics from various other doctors in the community under the pretense of using them for law enforcement purposes. Defendant's family had him hospitalized on two occasions in the beginning of 1981 in an attempt to detoxify him, but both times defendant received narcotics at the hospital from his deputies.

Finally, in August 1981, defendant suffered a toxic reaction. When his addiction then became public knowledge, defendant was no longer able to secure a supply of narcotics. After thirty-five days of hospitalization, he was finally detoxified and has not used narcotics since that time.

Defendant offered to produce expert and lay witnesses who would testify that he was addicted to narcotics; that drug addiction affects the brain both physiologically and psychologically; that because of the effect of narcotics on the brain, an addict has no choice but to continue taking drugs; and that defendant underwent a complete personality change during the advanced stages of his addiction.

The District Court rejected defendant's evidence of addiction as it related to his insanity defense on the authority of this Court's opinion in *Bailey v. United States*, 386 F.2d 1 (5th Cir. 1967), *cert. denied*, 392 U.S. 946 (1968). In that case, the Court held that narcotics addiction by itself does not justify acquittal by reason

of insanity. The District Court also relied on two policy considerations articulated by the Court of Appeals for the District of Columbia Circuit in *United States v. Moore*, 486 F.2d 1139 (D.C. Cir.) (en banc), cert. denied, 414 U.S. 980 (1973), i.e., that recognition of the theory urged by defendant would "open the floodgates" and would require acquittals in cases involving all sorts of crimes committed by addicts, and that Congress has indicated no intent to exempt addicts from federal narcotics laws. Likewise, the District Court concluded that defendant's evidence of addiction was insufficient to support a defense of compulsion or duress.

A panel of this Court reversed and remanded for a new trial on the ground that this case was indistinguishable from *United States v. Bass*, 490 F.2d 846 (5th Cir. 1974), where the Court held that evidence of a defendant's involuntary drug addiction is relevant to the issue of sanity. 704 F.2d 743 (5th Cir. 1983). The panel carefully limited its decision, noting that it was not holding that the mere allegation of drug addiction is a per se defense or that voluntary drug addiction constitutes a defense.

On July 8, 1983, this Court granted the Government's motion for rehearing en banc.

INTRODUCTION AND SUMMARY OF ARGUMENT

In *Blake v. United States*, 407 F.2d 908 (5th Cir. 1969) (en banc), this Court adopted the American Law Institute's (ALI) Model Penal Code definition of insanity. Under the version of that standard adopted by this Court:

- (1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental

disease or defect he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.

(2) As used in this Article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct.

Id. at 916.

Defendant can establish an insanity defense only if he proves that at the time of the crime he had a mental disease or defect and that, as a result of that disease or defect, he lacked substantial capacity to conform his conduct to the requirements of law.¹ Evidence of narcotics addiction may be probative of both issues.

Although the scientific literature supports defendant's argument that the narcotics prescribed by his physicians could well have led to his addiction (Part I), that literature does not clearly support the notion that addiction is itself a mental disease or defect. Nevertheless, significantly more researchers in the field subscribe to psychological theories of addiction than to physiological or sociological theories. None of the three groups of theories may by itself be sufficient to fully explain the nature and causes of addiction, and all may play a part in that explanation. But there is substantial agreement that addiction may be associated with a mental disease or defect in a variety of ways and that a disproportionate number of addicts have severe psychological disorders. Evidence of a defendant's addiction may, therefore, be relevant to

¹ The alternative, cognitive component of the ALI's Model Penal Code test requires proof that at the time of the crime the defendant lacked substantial capacity to appreciate the wrongfulness of his conduct. This component was not raised by defendant and therefore is not at issue in this case.

prove the existence of a mental disease or defect, a threshold requirement of this Court's definition of insanity. (Part II.)

Similarly, evidence of addiction may be relevant to the volitional prong of that definition—the defendant's ability to conform to legal requirements. Again, researchers have not reached a consensus on the precise degree to which addiction affects that ability. But the scientific literature supports defendant's argument that drug dependence has a profound impact on an addict's self-control and may compel the addict to go to any lengths to satisfy his habit. (Part III.)

In this case, therefore, the trial court erred in automatically excluding evidence proffered by defendant on the ground that addiction is not itself a mental disease or defect. Defendant claimed that he became addicted to various highly addictive narcotic analgesics that were prescribed by his physicians as part of his medical treatment, and that his capacity for self-control was severely impaired by his addiction. Accordingly, the District Court should have scrutinized defendant's claim with an eye towards determining whether the proffered evidence of addiction had any relevance to the insanity defense as defined by this Court.

ARGUMENT

I. The Scientific Evidence Supports Defendant's Contention that the Drugs Prescribed by His Physicians Are Highly Addictive Narcotic Opiates.

The drugs prescribed by defendant's physicians—Demerol, Percodan, Mepergan, and Talwin—contain narcotic analgesics with the same pharmacological qualities as morphine, heroin, and other opiates.² Demerol contains the synthetic narcotic analgesic meperidine³; the principal ingredient of Percodan is oxycodone, a semisynthetic narcotic analgesic; Mepergan is a combination of Demerol and anti-nausea medicine; and Talwin is a combination of the analgesic pentazocine and aspirin. See *Physicians' Desk Reference* 706, 2127, 939, 2171, 2139 (37th ed. 1983).

The narcotic analgesics reduce severe pain without simultaneously reducing other senses like sight, hearing,

² There are three types of narcotic analgesics: natural drugs—opium and the alkaloids of opium, such as morphine and codeine; semisynthetic drugs, such as heroin, prepared by the chemical synthesis of natural drugs; and synthetic drugs, such as meperidine, prepared from a nonopiate base. See R. LEVITT, *PSYCHOPHARMACOLOGY: A BIOLOGICAL APPROACH* 197 (1975).

³ Meperidine is the most widely prescribed narcotic analgesic and, aside from morphine and codeine, the most effective. See, e.g., R. JULIEN, *A PRIMER OF DRUG ACTION* 111 (3d ed. 1981); Jaffe & Martin, *Narcotic Analgesics and Antagonists*, in *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 245, 263 (L. Goodman & A. Gilman 5th ed. 1975); Special Project, *Drugs and Criminal Responsibility*, 33 VAND. L. REV. 1145, 1162 (1980) (hereinafter cited as VAND. Special Project). After codeine and Demerol, Percodan is the most frequently prescribed analgesic. See Blum, *Mind-Altering Drugs and Dangerous Behavior*, in *TASK FORCE ON NARCOTICS AND DRUG ABUSE, TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE* 40, 46 (1967).

Because meperidine is so effective and widely used, and because it was the addictive agent in two of the drugs on which defendant was dependent, this discussion includes a separate description of the effects of meperidine where appropriate.

or touch. The mechanism by which opiate narcotics relieve pain is not completely understood. Apparently, they do not actually reduce the transmission of pain impulses into the central nervous system. Instead, they may simply alter the patient's psychological response to pain and his perception of pain. Thus, painful sensations may continue to exist, but the patient may no longer recognize or be bothered by them.⁴

Opiate narcotics primarily affect the central nervous system. They create drowsiness, decrease the rate of respiration, and suppress the cough center. Opiates also have a variety of excitatory effects and may result in nausea and vomiting. In addition, they decrease the size of the pupil and have an effect on the gastrointestinal tract that makes them useful for treating diarrhea and dysentery.⁵

⁴ See, e.g., E. ABEL, *DRUGS AND BEHAVIOR: A PRIMER IN NEURO-PSYCHOPHARMACOLOGY* 192 (1974); R. JULIEN, *supra* note 3, at 105-06; C. KORNETSKY, *PHARMACOLOGY: DRUGS AFFECTING BEHAVIOR* 121-24 (1976); O. RAY, *DRUGS, SOCIETY, AND HUMAN BEHAVIOR* 199 (1972); Jaffe & Martin, *supra* note 3, at 248; VAND. Special Project, *supra* note 3, at 1159.

⁵ See, e.g., AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 142 (3d ed. 1980) (hereinafter cited as *DSM-III*); R. JULIEN, *supra* note 3, at 106-07; C. KORNETSKY, *supra* note 4, at 123-29; *PHYSICIANS' DESK REFERENCE* 706-07, 2127 (Demerol), 939 (Percodan), 2171 (Mepergan), 2140 (Talwin) (37th ed. 1983); O. RAY, *supra* note 4, at 199-200; Jaffe & Martin, *supra* note 3, at 247-54; VAND. Special Project, *supra* note 3, at 1159.

Meperidine has the same physiological effects as other opiates except that it dilates rather than constricts the size of the pupils. Compared with morphine, meperidine has one-tenth the strength; has a more rapid onset, taking effect within ten minutes; and has a shorter duration—from four to six hours. See, e.g., R. JULIEN, *supra* note 3, at 111-12; *PHYSICIANS' DESK REFERENCE*, *supra*, at 706-07; Jaffe & Martin, *supra* note 3, at 256, 263-65; VAND. Special Project, *supra* note 3, at 1162.

Narcotic analgesics also have a number of psychological effects. They produce mood changes and mental clouding, characterized by drowsiness, an inability to concentrate, apathy, decreased physical activity, and lethargy. In addition, these drugs generally produce a pleasant euphoric state. At first, however, some people experience dysphoria, characterized by anxiety, fear, nausea, and vomiting. But even if one's first exposure results in dysphoria, repeated use usually creates a state of euphoria, characterized by feelings of warmth, well-being, peacefulness, and contentment.⁶

Perhaps because of this euphoria, users of narcotic analgesics have a powerful compulsion to continue using the drug. The euphoric effect progressively decreases in intensity, however, as the individual develops a tolerance to the drug. The physiological causes of this phenomenon are not understood, but the results are clear; as tolerance develops, increased dosages of the drug must be administered to maintain a state of euphoria or prevent discomfort. Tolerance is manifested initially by a decrease in the duration of the analgesic effect, and subsequently by a decrease in the intensity of that effect.

Tolerance to opiate narcotics varies with the particular drug and physiological response, the dose, and the frequency of administration. Moreover, the rate at which tolerance develops varies widely among patients.⁷ But

⁶ See, e.g., E. ABEL, *supra* note 4, at 193; R. JULIEN, *supra* note 3, at 108; PHYSICIANS' DESK REFERENCE, *supra* note 5, at 707, 2127 (Demerol), 940 (Percodan), 2172 (Mepergan), 2140 (Talwin); Jaffe & Martin, *supra* note 3, at 247; VAND. Special Project, *supra* note 3, at 1159-60.

Like other narcotic analgesics, meperidine creates a euphoric state. See, e.g., Jaffe & Martin, *supra* note 3, at 266.

⁷ See, e.g., DSM-III, *supra* note 5, at 165; R. JULIEN, *supra* note 3, at 109; C. KORNETSKY, *supra* note 4, at 129-31; R. LEVITT, *supra*

the average addict can build up tolerance to a dosage of narcotics that is more than sufficient to kill the average person. See Bowman, *Narcotic Addiction and Criminal Responsibility Under Durham*, 53 Geo. L.J. 1017, 1038 (1965). Moreover, tolerance develops more quickly and lasts longer than was once thought. See R. Levitt, *Psychopharmacology: A Biological Approach* 221 (1975); see also C. Kornetsky, *Pharmacology: Drugs Affecting Behavior* 129 (1976) (tolerance develops "very quickly").

As tolerance develops and the dosage is increased, the body gradually develops a physical dependence on the narcotic.⁸ Physical dependence is characterized by an altered physiological state that necessitates continued administration of the drug to prevent the development of a withdrawal (or abstinence) syndrome. Physical depend-

note 2, at 215; PHYSICIANS' DESK REFERENCE, *supra* note 5, at 707, 2127 (Demerol), 939 (Percodan), 2171 (Mepergan), 2140 (tolerance develops rarely to the analgesic effect of Talwin); Bowman, *Narcotic Addiction and Criminal Responsibility Under Durham*, 53 GEO. L.J. 1017, 1038 (1965); Jaffe, *Drug Addiction and Drug Abuse*, in *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 284, 285, 295 (L. Goodman & A. Gilman 5th ed. 1975); Jaffe & Martin, *supra* note 3, at 254, 261, 266; VAND. Special Project, *supra* note 3, at 1158.

Continued use of meperidine also leads to tolerance, though at a somewhat slower rate than is the case with morphine. See, e.g., R. LEVITT, *supra* note 2, at 215; Jaffe & Martin, *supra* note 3, at 266.

⁸ Tolerance and physical dependence are independent phenomena, although physical dependence does not exist without tolerance. Tolerance may, however, develop without physical dependence. See, e.g., E. ABEL, *supra* note 4, at 118; C. KORNETSKY, *supra* note 4, at 129-30; R. LEVITT, *supra* note 2, at 222.

Continued use of a narcotic analgesic results not only in tolerance to and dependence on that particular opiate, but also in cross tolerance to and cross dependence on all other natural and synthetic opiates. See, e.g., R. JULIEN, *supra* note 3, at 109; Jaffe, *supra* note 7, at 289-90, 295; VAND. Special Project, *supra* note 3, at 1159.

ence and withdrawal symptoms are the result of drug-induced changes within the nervous system, particularly in the central nervous system. The degree of physical dependence varies with the particular drug, the frequency of administration, and the dosage administered.⁹ According to the *Physicians' Desk Reference*, *supra*, at 707, physical dependence may develop after only a few days of narcotic therapy and "assumes clinically significant proportions" after several weeks of continued narcotic use.

The symptoms of withdrawal from the opiate narcotics are similar to a severe case of the flu: craving for the drug, yawning, running nose, tearing, sweating, extreme anxiety, fever, chills, hot and cold flashes, extreme restlessness, irritability, dilated pupils, anorexia, gooseflesh, nausea, vomiting, increased respiratory rate, cramping, muscle spasms, intestinal cramps, elevated blood pressure, insomnia, diarrhea, and severe aches and pains.¹⁰

⁹ See, e.g., H. FINGARETTE & A. HASSE, *MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY* 146-47 n.41 (1979); R. JULIEN, *supra* note 3, at 110; C. KORNETSKY, *supra* note 4, at 129-31; R. LEVITT, *supra* note 2, at 222-24; *PHYSICIANS' DESK REFERENCE*, *supra* note 5, at 707, 2127 (Demerol), 939 (Percodan), 2171 (Mepergan), 2140 (Talwin); Jaffe, *supra* note 7, at 285, 288-91; Jaffe & Martin, *supra* note 3, at 254, 261; VAND. Special Project, *supra* note 3, at 1158-59.

Although meperidine was initially thought to be less addictive than other opiates, it has been found to cause the same side effects and to lead to physical dependence after continued use. See, e.g., C. KORNETSKY, *supra* note 4, at 132; R. LEVITT, *supra* note 2, at 214.

¹⁰ On opiate withdrawal generally, see, e.g., E. ABEL, *supra* note 4, at 194; DSM-III, *supra* note 5, at 144; H. FINGARETTE & A. HASSE, *supra* note 9, at 164-65; R. JULIEN, *supra* note 3, at 110; C. KORNETSKY, *supra* note 4, at 131; O. RAY, *supra* note 4, at 202-03; Bowman, *supra* note 7, at 1038; Jaffe, *supra* note 7, at 288, 295-97; VAND. Special Project, *supra* note 3, at 1159 & n.151.

Abstinence symptoms occur more rapidly after withdrawal from meperidine than after withdrawal from morphine, although they

These symptoms generally abate within ten days, although addicts do not regain physiological normalcy for some six months after withdrawal. During this period of the protracted abstinence syndrome, the addict may continue to experience insomnia, irritability, restlessness, malaise, pain, fatigue, premature ejaculation, and gastrointestinal hyperactivity and is prone to relapse into drug use.¹¹

The severity and duration of the withdrawal syndrome may vary depending on the particular drug, the degree of physical dependence, the total daily dose used, the interval between doses, the duration of use, the addict's health, personality, and state of mind, and the social-psychological setting. But withdrawal has been described variously as "nearly unbearable,"¹² "intensely distressing,"¹³ "extreme misery,"¹⁴ "very uncomfortable" and, for an addict with a large habit, "truly hell."¹⁵ The need to prevent the onset of withdrawal thus provides

typically are of shorter duration. See, e.g., R. LEVITT, *supra* note 2, at 215; Jaffe & Martin, *supra* note 3, at 267. With withdrawal from meperidine, the autonomic symptoms are not as prominent, the pupils may not be dilated, and there is usually little nausea, vomiting, or diarrhea. But one researcher has noted that "at peak intensity the muscle twitching, restlessness, and nervousness may be worse than during morphine withdrawal." Jaffe, *supra* note 7, at 297.

¹¹ See, e.g., C. KORNETSKY, *supra* note 4, at 131; Blum, *supra* note 3, at 54; Jaffe, *supra* note 7, at 296, 313-14; Winick, *Narcotics Addiction and Its Treatment*, 22 LAW & CONTEMP. PROBS. 9, 24 (1957).

¹² R. JULIEN, *supra* note 3, at 110.

¹³ H. FINGARETTE & A. HASSE, *supra* note 9, at 165.

¹⁴ Bowman, *supra* note 7, at 1039.

¹⁵ O. RAY, *supra* note 4, at 202-03.

another powerful motivation to continue use of the drug.¹⁶

In addition to—or instead of—physical dependence, some drug users may develop a psychological dependence on narcotic opiates. Such persons come to believe that continued use of the drug is necessary to produce pleasure or avoid discomfort, and they continue to take the drug because of its positive reinforcing effects. They “behave as if the effects produced by a drug, or the conditions associated with its use, are necessary to maintain an optimal state of well-being.” Jaffe, *Drug Addiction and Drug Abuse*, in *The Pharmacological Basis of Therapeutics* 284, 284 (L. Goodman & A. Gilman 5th ed. 1975). The intensity of this dependence may vary from a mild desire to a craving or compulsion to use the drug. See *id.* For certain drugs—but not the narcotic analgesics—this may be the only type of dependence resulting from continued use.¹⁷

Despite these adverse effects, opiates like those given defendant are widely prescribed because of their powerful analgesic effect. Thus far, no painkiller has been found that fails to result in tolerance and physical dependence. As a result of their addictive potential, physicians are expressly warned to exercise caution when prescribing narcotic analgesics, especially when the patient is being treated with more than one such drug.¹⁸

¹⁶ See, e.g., E. ABEL, *supra* note 4, at 116, 194; Francis, *Opiate Dependence and Tolerance: A Pharmacological Analysis*, in *THE BIOCHEMISTRY OF SCHIZOPHRENIA AND ADDICTION* 227, 227 (G. Hemmings ed. 1980).

¹⁷ See, e.g., E. ABEL, *supra* note 4, at 115-17; C. KORNITSKY, *supra* note 4, at 186; R. LEVITT, *supra* note 2, at 225; PHYSICIANS' DESK REFERENCE, *supra* note 5, at 707, 2127 (Demerol), 939 (Percodan), 2171 (Mepergan), 2140 (Talwin).

¹⁸ See PHYSICIANS' DESK REFERENCE, *supra* note 5, at 706 (Demerol), 939 (Percodan), 2171 (Mepergan) (“WARNING: May

Some persons, like defendant, become addicted after receiving narcotics as part of medical treatment for physical illness. The precise incidence of iatrogenic addiction is unknown, and some portion of such addiction is probably not reported. Some researchers believe that iatrogenic addiction to narcotic analgesics is uncommon considering the frequency with which those drugs are used. And only a very small percentage of the drug-dependent population become addicts as a result of medical treatment. Nevertheless, one researcher has observed that "many patients become physically and psychologically dependent on the prescribed drugs." C. Kornetsky, *supra*, at 185.¹⁹ And because meperidine is the narcotic analgesic most widely prescribed for pain relief in hospitalized patients, it is "an extremely commonly encountered agent in physician-induced addiction of patients." R. Julien, *A Primer of Drug Action* 111 (3d ed. 1981).

Here, defendant maintains that he became addicted to various narcotics analgesics, including meperidine, after they were prescribed almost continuously, and in ever increasing amounts, for a period of more than two years. For a good part of this period, moreover, defendant was simultaneously taking more than one of these drugs. His

be habit forming"); *id.* at 707, 2127 (Demerol), 2171 (Mepergan) ("should be used with great caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics . . ."); *id.* at 2140 (Talwin) ("Patients with a history of drug dependence should be under close supervision while receiving TALWIN Compound orally.").

¹⁹ But see Bowman, *supra* note 7, at 1030 n.57 (although iatrogenic addicts may develop a physical dependence on narcotics, they usually develop little or no psychological dependence and therefore are not likely to relapse after undergoing withdrawal).

On physician-induced addiction to opiates generally, see, *e.g.*, H. FINGARETTE & A. HASSE, *supra* note 9, at 152 n.60, 156; Blum, *supra* note 3, at 46-48; Bowman, *supra* note 7, at 1030; Jaffe, *supra* note 7, at 293.

contention that he became addicted to these drugs as a result of his long-standing medical treatment is corroborated by the scientific evidence of the highly addictive nature of the narcotic analgesics.

II. Although the Scientific Evidence Does Not Clearly Indicate Whether Drug Addiction Itself Is a Mental Disease or Defect, Evidence of a Defendant's Drug Addiction Should Not Automatically Be Excluded in All Cases.

Scientists have proposed a number of theories of addiction, no one of which completely explains the causes and nature of narcotics addiction or has gained unanimous approval of researchers in the field. The theories that emphasize psychological factors in attempting to explain addiction do, however, have the largest following. Although those theories do not fully support the argument that drug addiction is itself a mental disease or defect within the terms of this Court's definition of insanity, they do suggest a number of ways in which addiction may be related to such diseases or defects. Accordingly, evidence of addiction should not be excluded in all cases when offered to support an insanity defense.

A. Physiological Theories Do Not Completely Explain Addiction.

As explained in Part I, *supra*, drugs like narcotic analgesics have been shown to have definite physiological effects. Some researchers therefore emphasize physiological factors in attempting to explain addiction. For example, some scientists believe that narcotics produce a long-lasting metabolic change in the brain that may explain addicts' craving for drugs. See R. Levitt, *Psy-*

chopharmacology: A Biological Approach 230 (1975).²⁰ But the physiological impact of the drugs is not alone an adequate explanation because not all users become drug dependent. Some researchers point out that only a small minority of those who receive narcotic analgesics as part of medical treatment become known addicts, and that some recreational opiate users take drugs periodically without ever becoming dependent.²¹ Moreover, many drug users—including addicts—eventually choose to give up their drug habit, usually when they reach the age of forty or fifty.²²

A study of heroin use by Vietnam veterans corroborates the hypotheses that drug use may be temporary and is not necessarily addictive. Pure forms of heroin and other drugs were widely available in Vietnam at a low cost. "[A]lmost every soldier had the opportunity to experiment with heroin, and almost all personally knew other soldiers who used heroin with some regularity." L. Robins, *A Follow-Up of Vietnam Drug Users* 22 (Special Action Office Monograph, Special Office for Drug Abuse Prevention, Executive Office of the Presi-

²⁰ See also S. PEELE, *THE SCIENCE OF EXPERIENCE: A DIRECTION FOR PSYCHOLOGY* 106 (1983); *Powell v. Texas*, 392 U.S. 514, 561 (1968) (Fortas, J., dissenting) (discussing physiological theories regarding alcoholism).

²¹ See, e.g., H. FINGARETTE & A. HASSE, *supra* note 9, at 156-57; S. PEELE, *supra* note 20, at 68-69, 81-82; Blum, *supra* note 3, at 46-48; Bowman, *supra* note 7, at 1036; Jaffe, *supra* note 7, at 293; Zinberg, *Nonaddictive Opiate Use*, in *HANDBOOK ON DRUG ABUSE* 303, 305-06 (R. Dupont, A. Goldstein, & J. O'Donnell ed. 1979).

According to one researcher, however, the only regular users of heroin who do not become addicts are the few who limit their drug intake to small amounts. See Robins, *Addict Careers*, in *HANDBOOK ON DRUG ABUSE* 325, 326 (R. Dupont, A. Goldstein, & J. O'Donnell ed. 1979).

²² See, e.g., H. FINGARETTE & A. HASSE, *supra* note 9, at 157; O. RAY, *supra* note 4, at 196; Jaffe, *supra* note 7, at 316; Robins, *supra* note 21, at 332-33.

dent, U.S. Gov't Printing Office Series A, No. 1, 1973). In September 1971, and then again about a year later, the study examined all 13,240 Army enlisted men then returning from Vietnam. Almost half had tried heroin or opium while in Vietnam, but only about twenty percent developed signs of physical or psychological dependence—indicating that one does not automatically become “hooked” by using drugs. Moreover, only one percent of the total showed any signs of addiction after their return to this country—indicating that addiction is not necessarily permanent.²³ In fact, the researcher found even more startling evidence of both points: one-fifth of the former addicts continued to use opiates occasionally after their return, but only about twelve percent of that group experienced any period of addiction in this country. See L. Robins, *Veterans' Drug Use Three Years After Vietnam* (Report to the National Institute of Drug Abuse 1976); L. Robins, *A Follow-Up of Vietnam Drug Users*, *supra*, at 22-23.²⁴

To account for these phenomena, some theorists suggest that the physiological effects of narcotics produce addiction only in those drug users who have a particular sensitivity—perhaps genetically determined—to the drug. See, e.g., Dole & Nyswander, *Methadone Maintenance and Its Implications for Theories of Drug Addiction*, in

²³ This finding was confirmed in Zinberg, *Rehabilitation of Heroin Users in Vietnam*, 1 CONTEMPORARY DRUG PROBS. 263 (1972). See also L. ROBINS, THE VIETNAM DRUG USER RETURNS (Special Action Office Monograph, Special Office for Drug Abuse Prevention, Executive Office of the President, U.S. Gov't Printing Office Series A, No. 2, 1974).

²⁴ In her final report, however, the researcher observed that the pattern of opiate use by Vietnam veterans was not random, but was related to predictors such as prior drug use, education, age, arrest record, and service status (enlisted, draftee, or career officer). See L. ROBINS, *supra* note 23, at 38.)

The Addictive States 359, 359 (A. Wikler ed. 1968). These hypotheses have been criticized, however, as speculative and unsupported by medical evidence or consensus.²⁵ Moreover, they do not explain why addictive patterns of conduct are associated with drugs such as cocaine and LSD that produce only psychological dependence and not physical dependence.²⁶

B. Sociological Theories Do Not Completely Explain Addiction.

A second set of theories advanced to explain narcotics addiction emphasizes the sociological aspects of drug dependence. Researchers subscribing to these theories point out that a large proportion of the more recent addicts in this country are young, immature, uneducated, unskilled, alienated, and economically disadvantaged residents of urban areas. Such persons may attain a sense of identity, status, or acceptance among members of the drug culture not available to them through more legitimate channels because of the disadvantages from which they suffer. Similarly, they may use drugs in response to pressure from their peers.²⁷

²⁵ See, e.g., H. FINGARETTE & A. HASSE, *supra* note 9, at 162-64; A. GOLDSTEIN, L. ARONOW, & S. KALMAN, *THE PRINCIPLES OF DRUG ACTION* 474 (1969); DeLong, *The Drugs and Their Effects*, in *DEALING WITH DRUG ABUSE: A REPORT TO THE FORD FOUNDATION* 62, 212 (1972).

²⁶ See, e.g., DSM-III, *supra* note 5, at 166; Jaffe, *supra* note 7, at 311; VAND. Special Project, *supra* note 3, at 1146, 1153.

²⁷ See, e.g., H. FINGARETTE & A. HASSE, *supra* note 9, at 159-60; Blum, *supra* note 3, at 49-51; Bowman, *supra* note 7, at 1034; Jaffe, *supra* note 7, at 292; Nurco, *Etiological Aspects of Drug Abuse*, in *HANDBOOK ON DRUG ABUSE* 315, 315 (R. Dupont, A. Goldstein, & J. O'Donnell ed. 1979). See also *Powell v. Texas*, 392 U.S. 514, 561 (1968) (Fortas, J., dissenting) (discussing sociological theories regarding alcoholism).

These theories have been criticized on the ground that no single social factor accounts for drug use. Such factors may contribute to an environment in which drug addiction is more likely to flourish, or in which opportunities for drug use exist, but by themselves they do not create drug addicts. Moreover, many persons are exposed to narcotics in economically depressed metropolitan areas without becoming addicted.²⁸

C. Although Psychological Theories Do Not Completely Explain Addiction and Do Not Clearly Indicate Whether Addiction Itself Is a Mental Disease or Defect, They Are the Most Widely Accepted Explanations of Addiction.

A final group of theories offered to explain drug dependence, which is the most pertinent here as well as the most widely accepted, emphasizes the psychological aspects of addiction. These researchers suggest that persons with certain psychological dysfunctions or character disorders are more vulnerable to the effects of narcotics and therefore more likely to become addicted.

Some researchers subscribing to the psychological theories of addiction point out that most narcotics addicts suffer from underlying mental disorders that predated and probably contributed to their use of narcotics.²⁹

²⁸ See, e.g., I. CHEIN, D. GERARD, R. LEE, & E. ROSENFELD, *THE ROAD TO H* (1964) (hereinafter cited as I. CHEIN); C. KORNETSKY, *supra* note 4, at 196-97; Blum, *supra* note 3, at 49; Bowman, *supra* note 7, at 1034-35; Hill, Haertzen, & Glaser, *Personality Characteristics of Narcotic Addicts as Indicated by the MMPI*, 62 J. GENERAL PSYCHOLOGY 127, 136 (1960).

In fact, one group of researchers found that the Hispanic and Caucasian drug users studied came from homes of less socioeconomic deprivation than did nonusers living in the same urban areas, although the opposite was true for Black subjects. See I. CHEIN, *supra*.

²⁹ See, e.g., I. CHEIN, *supra* note 28, at 194; DSM-III, *supra* note 5, at 164, 168; L. KOLB, *DRUG ADDICTION: A MEDICAL PROBLEM* 85

Others believe that narcotic use or dependence is the cause rather than the effect of mental disorders.³⁰ Whichever direction the causal relationship goes, these researchers agree that all addicts, with a few exceptions, can be diagnosed as having one of three psychological problems: personality disturbances; psychoneuroses; and psychoses.³¹ The class of exceptions is usually considered to consist of the small number of addicts who are mentally healthy individuals and become addicted accidentally—either medical patients or newborns whose mothers used drugs during pregnancy. Nevertheless, some researchers have found that even iatrogenic addicts “have some fundamental emotional problem that caused them to continue the use of drugs beyond the period of medical need.” A. Noyes & L. Kolb, *Modern Clinical Psychiatry* 475 (6th ed. 1963).³²

The majority of addicts fall into the first category and have some form of personality disturbance,³³ such as

(1962); Bennett, *Drug Addiction and Its Effect on Criminal Responsibility*, 9 WAKE FOREST L. REV. 179, 183 (1973); Blachly, *Theories of Addiction*, in DRUG ABUSE NOW 192, 197 (P. Blachly ed. 1972); Bowman, *supra* note 7, at 1029, 1036; Hill, Haertzen, & Glaser, *supra* note 28, at 136-37; Korin, *Comparison of Psychometric Measures in Psychiatric Patients Using Heroin and Other Drugs*, 83 J. ABNORMAL PSYCHOLOGY 208, 208 (1974); Smart & Jones, *Illicit LSD Users: Their Personality Characteristics and Psychopathology*, 75 J. ABNORMAL PSYCHOLOGY 286, 291-92 (1970).

³⁰ See, e.g., DSM-III, *supra* note 5, at 167; Robins, *supra* note 21, at 328.

³¹ See Felix, *An Appraisal of the Personality Types of the Addict*, 100 AM. J. PSYCHIATRY 462, 465 (1944). See also, e.g., Bennett, *supra* note 29, at 183; Bowman, *supra* note 7, at 1029-30; Hill, Haertzen, & Glaser, *supra* note 28, at 135; Korin, *supra* note 29, at 208.

³² But cf. Jaffe, *supra* note 7, at 293 (the personality characteristics of iatrogenic addicts differ from those of “the urban heroin addict”).

³³ See, e.g., I. CHEIN, *supra* note 28, at 14, 194; Bowman, *supra* note 7, at 1031 & n.60; Gilbert & Lombardi, *Personality Char-*

psychopathy, sociopathy, or conduct disorder.³⁴ Frequently, these individuals are dissatisfied with the impact of their behavior on others or with their ability to function effectively. A substantial number of them are diagnosed as having inadequate personalities, characterized by inadequate responses to intellectual, emotional, social, and physical demands. The resulting anxieties and frustrations cause hostility, immaturity, and aggressiveness, which are alleviated by the pleasurable and peaceful effects of the drug. In the words of one group of researchers, "[t]he addiction . . . offers an answer to even th[e] problem of emptiness. The life of an addict constitutes a vocation . . .—a vocation around which the addict can build a reasonably full life." I. Chein, D. Gerard, R. Lee, & E. Rosenfeld, *The Road to H* 23-24 (1964). Another researcher agreed, concluding that "psychopath[s] receive from narcotics a pleasurable sense of relief from the realities of life that normal persons do not receive because life is no special burden to them." L. Kolb, *Drug Addiction: A Medical Problem* 85 (1962). The various types of personality disturbances

acteristics of Young Male Narcotic Addicts, 31 J. CONSULTING PSYCHOLOGY 536, 538 (1967); Hill, Haertzen, & Glaser, *supra* note 28, at 135, 136, 138; Smart & Jones, *supra* note 29, at 289; Sutker & Allain, *Incarcerated and Street Heroin Addicts: A Personality Comparison*, 32 PSYCHOLOGICAL REP. 243, 243 (1973).

³⁴ Psychopathy and sociopathy are characterized by "a history of continuous and chronic antisocial behavior in which the rights of others are violated, persistence into adult life of a pattern of antisocial behavior that began before the age of 15, and failure to sustain good job performance over a period of several years" DSM-III, *supra* note 5, at 317-18.

A conduct disorder consists of the typical childhood signs of psychopathy and sociopathy and is usually first evident in children and adolescents. Its essential feature is "a repetitive and persistent pattern of conduct in which the basic rights of others or major age-appropriate societal norms or rules are violated." *Id.* at 319, 45.

are not usually considered mental diseases or defects within the legal definition of insanity.³⁵

Psychoneurotic individuals,³⁶ who account for a substantial minority of the addict population, are considered by the legal system to have a mental disease.³⁷ Such persons exhibit anxiety resulting from either repressed emotions, aggressive impulses, or external threats or losses. Many of them adopt defense mechanisms, such as physical symptoms, phobias, compulsive behavior, and insom-

³⁵ Compare *United States v. Kohlman*, 469 F.2d 247, 250 (2d Cir. 1972) (noting that defendant need not be psychotic to have a mental disease and that Government's expert admitted that a psychopath may be insane); *King v. United States*, 372 F.2d 383, 385-86, 388 (D.C. Cir. 1967) (personality disorder can be a mental disease); *Overholser v. O'Beirne*, 302 F.2d 852, 856 & nn.9-10, 857 & n.12 (D.C. Cir. 1962) (observing that sociopathy per se may support a verdict of insanity, although noting that scientific experts disagree whether sociopathy and psychopathy are mental diseases); *Stewart v. United States*, 214 F.2d 879, 882 (D.C. Cir. 1954) (reversing conviction because instruction that psychopathy is not a mental disease invaded the province of the jury), with *United States v. Robertson*, 507 F.2d 1148, 1153 (D.C. Cir. 1974) (expert testifies that sociopath is not mentally ill); *United States v. Harper*, 450 F.2d 1032, 1042-43 (5th Cir. 1971) (Government expert testifies that a personality disorder is not a mental disease); *United States v. O'Neal*, 431 F.2d 695, 696 (5th Cir. 1970), cert. denied, 401 U.S. 917 (1971) (suggesting that sociopathy is not a mental disease).

Moreover, some researchers have argued that the concept of personality disorder does not distinguish the addict from other persons "who have a tendency to get into difficulties with the law and with their neighbors and who often manifest no discernible mental abnormalities." H. FINGARETTE & A. HASSE, *supra* note 9, at 169.

³⁶ A neurotic disorder is "a mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing to the individual and is recognized by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact; behavior does not actively violate gross social norms (although functioning may be markedly impaired); the disturbance is relatively enduring or recurrent without treatment and is not limited to a transitory reaction to stressors; and there is no demonstrable organic etiology or factor." DSM-III, *supra* note 5, at 9-10.

³⁷ See, e.g., W. LAFAYE & A. SCOTT, CRIMINAL LAW 275 (1972).

nia that enable them to believe that their weaknesses are the result of their illness rather than a more fundamental personal defect. Drugs afford these addicts relief from their pains and phobias and also from psychic tension and anxiety. They may come to believe that continued use of narcotics is necessary for their physical health.³⁸

Drug addicts with psychoses, such as schizophrenia³⁹ and manic-depressive psychoses,⁴⁰ have severe mental disorders within the legal definition of insanity.⁴¹ The per-

³⁸ See, e.g., Bowman, *supra* note 7, at 1032; Gilbert & Lombardi, *supra* note 33, at 538; see also Sutker & Allain, *supra* note 33, at 244-45 (unincarcerated addicts exhibit more symptoms of neurosis than either incarcerated nonaddict prisoners or incarcerated addict prisoners).

³⁹ Schizophrenia is characterized by multiple psychological disturbances such as a loosening of associations and perhaps incoherence, an inappropriate blunting of emotion or sudden and unpredictable changes in emotion, a disturbed sense of self, frequently manifested by perplexity about one's identity and the meaning of existence, and a tendency to withdraw from involvement with the external world; deterioration from a previous level of functioning in such areas as work, social relations, and self-care; onset before the age of forty-five; and a duration of at least six months. At some phase schizophrenia always involves delusions, hallucinations, or certain disturbances in the form of thought. DSM-III, *supra* note 5, at 181-84.

⁴⁰ Manic psychosis is characterized by a predominant mood that is "either elevated, expansive, or irritable . . ." and by the presence of other symptoms—including "hyperactivity, pressure of speech, flight of ideas, inflated self-esteem, decreased need for sleep, distractibility, and excessive involvement in activities that have a high potential for painful consequences, which is not recognized." DSM-III, *supra* note 5, at 206. Depressive psychosis is characterized by a "loss of interest or pleasure in all or almost all usual activities and pastimes." *Id.* at 210. Persons suffering from manic-depressive psychosis exhibit cycles of both manic and depressive moods.

⁴¹ See, e.g., *United States v. Fratus*, 530 F.2d 644, 648 (5th Cir.), *cert. denied*, 429 U.S. 846 (1976) (paranoid schizophrenia); *Millard v. Harris*, 406 F.2d 964, 968 (D.C. Cir. 1968) (psychosis); W. LaFAVE & A. SCOTT, *supra* note 37, at 275.

centage of drug addicts who are psychotic is not known. One researcher has observed that these persons make up only a small fraction of the addict population.⁴² But two other studies concluded that twenty-three percent⁴³ and thirteen percent⁴⁴ of the addicts examined were psychotic. Without doubt, however, a recognizable proportion of narcotic addicts are severely mentally disabled.

Empirical research supports the assertion that a disproportionate number of addicts have diagnosable mental disorders. In one study, psychologists and psychiatrists examined young male addicts and a control group by administering various psychological tests and conducting clinical interviews. The researchers found evidence of greater pathology among the addicts: they diagnosed nineteen percent as schizophrenics and twenty-five percent as incipient schizophrenics, or "borderline status." In fact, none of the addicts—compared with half of the control group—were diagnosed as normal adolescents. See Gerard & Kornetsky, *Adolescent Opiate Addiction: A Study of Control and Addict Subjects*, 29 *Psychiatric Q.* 457 (1955). Another study of addicts that used prisoners as the control population reached similar conclusions. See Sutker, *Personality Differences and Sociopathy in Heroin Addicts and Nonaddict Prisoners*, 78 *J. Abnormal Psychology* 247, 250 (1971).

Additional studies based on administration of the Minnesota Multiphasic Personality Inventory have concluded that "there seems to be deeper and more widespread

⁴² See Bowman, *supra* note 7, at 1032.

⁴³ See Sutker, *Personality Differences and Sociopathy in Heroin Addicts and Nonaddict Prisoners*, 78 *J. ABNORMAL PSYCHOLOGY* 247, 250-51 (1971).

⁴⁴ See Smart & Jones, *supra* note 29, at 289.

pathology among addicts than among nonaddicts"⁴⁵; that "the LSD users showed far greater psychological disturbances than the nonusers, and that much of this psychopathology predated drug use"⁴⁶; and that, although only five and one-half percent of the addicts studied could be diagnosed as normal, thirty-six percent showed either neurotic or schizophrenic symptoms.⁴⁷

Some researchers have hypothesized that narcotics serve a functional and even therapeutic purpose for some addicts whose use of drugs prevents the onset of a more severe psychopathology.⁴⁸ These persons are better able to function as addicts because for them narcotics provide "a means to counteract the disorganizing influences of rage and aggression, affects with which addicts have particular difficulty." Khantzian, *Opiate Addiction: A Critique of Theory and Some Implications for Treatment*, 28 Am. J. Psychotherapy 59 (1974).

Although experts in the field tend to agree that psychological factors play an important role in the development of drug dependence and that a significant number of addicts have mental disorders, they do not agree that psychological theories completely explain the nature and

⁴⁵ Gilbert & Lombardi, *supra* note 33, at 538.

⁴⁶ Smart & Jones, *supra* note 29, at 291. These researchers concluded that 96% of the addicts studied were abnormal, 23% had a conduct disorder, 13% were psychotic, and 1% were psychoneurotic. *See id.* at 289.

⁴⁷ *See* Hill, Haertzen, & Glaser, *supra* note 28, at 131-34.

⁴⁸ *See, e.g.,* I. CHEIN, *supra* note 28, at 194; G. CLARIDGE, DRUGS AND HUMAN BEHAVIOR 230 (1970); Bourne, *Issues in Addiction*, in ADDICTION (P. Bourne ed. 1974); Gerard & Kornetsky, *Adolescent Opiate Addiction: A Study of Control and Addict Subjects*, 29 PSYCHIATRIC Q. 457 (1955); Khantzian, *Opiate Addiction: A Critique of Theory and Some Implications for Treatment*, 28 AM. J. PSYCHOTHERAPY 59 (1974).

causes of addiction or that the presence of addiction is indicative of a particular mental disease in all cases. Some researchers point out, for example, that addicts do not fall into one diagnostic category and that no trait or set of traits has been identified that applies to all drug-dependent persons. Moreover, individual addicts may exhibit a mix of traits and symptoms.⁴⁹ Similarly, the theory that drug use prevents the onset of more severe psychological breakdown in some addicts has been challenged as insufficiently documented and exceedingly difficult to prove.⁵⁰

Although the psychological theories of addiction have received wider approval in the scientific literature than the physiological and sociological theories, there is no consensus supporting the argument that drug addiction itself is a mental disease or defect.⁵¹ Rather, scientists

⁴⁹ See, e.g., G. CLARIDGE, *supra* note 48, at 229; H. FINGARETTE & A. HASSE, *supra* note 9, at 169; C. KORNETSKY, *supra* note 4, at 190-91, 192; O. RAY, *supra* note 4, at 203; Bowman, *supra* note 7, at 1032-33; Gendreau & Gendreau, *A Theoretical Note on Personality Characteristics of Heroin Addicts*, 82 J. ABNORMAL PSYCHOLOGY 139, 139 (1973); Jaffe, *supra* note 7, at 286, 292.

These criticisms are not surprising given the diverse pharmacological effects of various drugs. See *id.* at 292.

⁵⁰ See C. KORNETSKY, *supra* note 4, at 194-95.

⁵¹ Some researchers have attempted to explain narcotics addiction by using a conditioned learning approach, which combines elements of the physiological and psychological theories described above. Relying on experiments testing drug use by animals, these theorists suggest that drugs are powerful reinforcers and that their effects—producing euphoria and preventing withdrawal, or both—provide overpowering motivations for addictive behavior. See, e.g., A. LINDESMITH, ADDICTION AND OPIATES 186-88 (1968); Jaffe, *supra* note 7, at 286; Wikler, *Dynamics of Drug Dependence: Implications of a Conditioning Theory for Research and Treatment*, in OPIATE ADDICTION: ORIGINS AND TREATMENT 7 (S. Fisher & A. Freedman ed. 1970).

The conditioned learning theories have been challenged on the ground that the factors motivating humans are more complex than

believe that numerous factors—including the physiological, sociological, and psychological factors described above—interact to explain drug dependence and that no one theory can account for addiction.⁵²

This lack of agreement in the scientific community is consistent with the conflicting perception of drug addiction in the legal community. Some courts seemingly consider addiction a mental disease or defect in itself.⁵³ Moreover, a number of states permit civil commitment on the mere showing of narcotics addiction and, therefore, presumably consider addiction some form of mental dis-

are those motivating animals, so that the reinforcing effects of drugs cannot themselves determine a whole way of life. See H. FINGARETTE & A. HASSE, *supra* note 9, at 165-66; S. PEELE, *supra* note 20, at 77. Others have made the similar argument that withdrawal is not adverse enough and drug-induced euphoria—which becomes less frequent as tolerance develops—is not positive enough to provide such a powerful motivation. See H. FINGARETTE & A. HASSE, *supra* note 9, at 164-65, 167.

⁵² See, e.g., G. CLARIDGE, *supra* note 48, at 228; H. FINGARETTE & A. HASSE, *supra* note 9, at 161, 192; C. KORNETSKY, *supra* note 4, at 199, 218; S. PEELE, *supra* note 20, at 73, 106; Nurco, *supra* note 27, at 322; see also *State v. Plummer*, 117 N.H. 320, 374 A.2d 431, 435 (1977).

⁵³ See *United States v. McKnight*, 427 F.2d 75 (7th Cir.), *cert. denied*, 400 U.S. 880 (1970); *Castle v. United States*, 347 F.2d 492, 494 (D.C. Cir. 1964), *cert. denied*, 381 U.S. 929, 953 (1965); *Faught v. State*, 155 Ind. App. 520, 293 N.E.2d 506 (1973); *Prather v. Commonwealth*, 215 Ky. 714, 287 S.W. 559 (1926); *State v. Flores*, 82 N.M. 480, 483 P.2d 1320 (N.M. Ct. App. 1971); cf. *Hightower v. United States*, 325 F.2d 616 (D.C. Cir. 1964) (*per curiam*), *cert. denied*, 384 U.S. 994 (1966) (seemingly accepting that defendant's addiction was a mental disease, but affirming conviction on the ground that defendant did not prove that his crime was the product of that mental disease as required by the *Durham* rule); *Fisher v. State*, 54 Del. 542, 182 A.2d 333, 335 (1962) (same); *State v. Plummer*, 117 N.H. 320, 374 A.2d 431, 436 (1977) (recognizing alcoholism as a mental disease). See also Bowman, *supra* note 7, at 1042-43.

ease.⁶⁴ But the majority of the courts have refused to recognize addiction as itself a mental disease or defect.⁶⁵ The courts' opinions on both sides of the issue all have the fatal flaw of reaching their conclusion by fiat with-

⁶⁴ As of 1973, twenty-four of the thirty-four states with civil commitment programs permitted commitment on a showing of addiction alone without even requiring proof of dangerousness. See Comment, *Criminal Responsibility and the Drug Dependence Defense—A Need for Judicial Clarification*, 42 FORDHAM L. REV. 361, 385 n.152 (1973).

⁶⁵ See, e.g., *United States v. Coffman*, 567 F.2d 960, 963 (10th Cir. 1977); *Brinkley v. United States*, 498 F.2d 505, 511 (8th Cir. 1974); *United States v. Stevens*, 461 F.2d 317, 321 (7th Cir.), cert. denied, 409 U.S. 948 (1972); *Gaskins v. United States*, 410 F.2d 987, 989 (D.C. Cir. 1967); *Bailey v. United States*, 386 F.2d 1, 4 (5th Cir. 1967), cert. denied, 392 U.S. 946 (1968); *United States v. Freeman*, 357 F.2d 606, 625 (2d Cir. 1966); *Heard v. United States*, 348 F.2d 43, 44 (D.C. Cir. 1964) (per curiam); *Martin v. United States*, 327 F. Supp. 126, 129 (W.D. Pa. 1971), aff'd, 463 F.2d 220 (3d Cir. 1972) (per curiam); *Berry v. United States*, 286 F. Supp. 816, 820 (E.D. Pa. 1968), rev'd on other grounds, 412 F.2d 189 (3d Cir. 1969); *Murphy v. State*, 265 Ind. 116, 352 N.E.2d 479, 485 (1976); *Commonwealth v. Sheehan*, 376 Mass. 765, 383 N.E.2d 1115, 1119 (1978); *Dorsey v. State*, 586 S.W.2d 810, 811 (Mo. Ct. App. 1979); *State v. White*, 27 N.J. 158, 142 A.2d 65, 68 (1958). Cf. *United States v. Poolaw*, 588 F.2d 103, 105 (5th Cir. 1974) (alcoholism is not a mental disease); *Biggs v. United States*, 318 F. Supp. 212, 214 (N.D. Fla. 1970) (same).

Although members of the scientific and legal communities do not all agree that drug addiction is a mental disease, there is substantial agreement that it is a disease. See, e.g., *Robinson v. California*, 370 U.S. 660, 666-67 (1962) (referring to addiction as "an illness" and comparing it to mental illness, leprosy, and venereal disease); *id.* at 669-78 (Douglas, J., concurring) (quoting, *inter alia*, S. REP. NO. 1440, 84th Cong., 2d Sess. 2 (1956); H.R. REP. NO. 2388, 84th Cong., 2d Sess. 8 (1956)); *Linder v. United States*, 268 U.S. 5, 18 (1925) (referring to addicts as "diseased and proper subjects for [medical] treatment . . ."); *In re Foss*, 10 Cal. 3d 910, 519 P.2d 1073, 1079, 112 Cal. Rptr. 649, 655 (1974); 34 C.F.R. part 104 App. A, at 350 (1982) (concluding that drug addicts and alcoholics have a "physical or mental impairment" within the meaning of § 7(6) of the Rehabilitation Act of 1973, 29 U.S.C. § 706(7), because "[t]here is a medical and legal consensus that alcoholism and drug addiction are diseases, although there is disagreement as to whether they are primarily mental or physical").

out reasoned elaboration or supporting empirical evidence, and do not, therefore, provide significant help in resolving the question whether addiction is itself a mental disease or defect.

D. Evidence of Addiction May Be Relevant to an Insanity Defense.

Although the scientific literature does not fully support the argument that addiction is itself a mental disease or defect, evidence of a defendant's drug dependence should not automatically be excluded when offered in support of an insanity defense. Such evidence might be relevant to that defense in a number of ways, and courts have almost uniformly admitted evidence of addiction in those contexts.

As discussed above, there is substantial evidence indicating that some addicts have psychological defects of one type or another that predated and perhaps contributed to their drug dependence. See pages 20-26, *supra*. Testimony about a defendant's addiction may, therefore, indicate the existence of an underlying mental disease or defect that is explained, at least in part, by the defendant's drug use. Courts have recognized that addiction may be caused by an underlying mental disease or defect and may be a symptom of that disease.⁵⁸ Evidence of the de-

⁵⁸ See, e.g., *Robinson v. California*, 370 U.S. 660, 672 (1962) (Douglas, J., concurring) (citing H.R. REP. NO. 2388, 84th Cong., 2d Sess. 8 (1956)); *Watson v. United States*, 439 F.2d 442, 460 (D.C. Cir. 1970) (Bazelon, C.J., concurring in part and dissenting in part); *Gaskins v. United States*, 410 F.2d 987, 989 (D.C. Cir. 1967); *Heard v. United States*, 348 F.2d 43, 49 (D.C. Cir. 1964) (Bazelon, C.J., statement on denial of rehearing en banc); *Castle v. United States*, 347 F.2d 492, 494 (D.C. Cir. 1964), *cert. denied*, 381 U.S. 929, 953 (1965); *id.* at 495, 497 (Burger, J., concurring in the result); *Hightower v. United States*, 325 F.2d 616, 620-21 (D.C. Cir. 1964) (Fahy, J., dissenting), *cert. denied*, 384 U.S. 994 (1966).

fendant's addiction should be admitted in such cases to corroborate the existence of the defendant's illness.

Other courts have admitted evidence that a defendant who suffered from a mental disease or defect used drugs in an effort to alleviate that illness. In *United States v. Cooper*, 465 F.2d 451, 452 (9th Cir. 1973), for example, expert testimony was admitted indicating that the defendant, who suffered from a chronic anxiety reaction with moderately severe depression and a schizoid personality, took narcotics to control his emotional symptoms. Similarly, in *United States v. Carter*, 436 F.2d 200, 201-02 (D.C. Cir. 1970) (per curiam), the court recognized that a defendant suffering from an anxiety reaction, a recognized mental disease, might have taken drugs to alleviate that reaction.

In addition, courts have recognized that narcotics use may create a permanent or temporary⁵⁷ psychosis in a previously healthy addict, and they have admitted evidence of the defendant's drug use as proof of that psychosis. The fact that drug use is the underlying cause of the defendant's insanity in such cases does not defeat the defense—even if the drug use was voluntary—as long as the defendant was rendered insane under the applicable legal definition.⁵⁸

⁵⁷ A mental disease or defect need not be permanent or even long-lasting to come within the legal definition of insanity; temporary insanity is also recognized as a defense. See, e.g., *United States v. Bass*, 490 F.2d 846, 851 (5th Cir. 1974); *People v. Kelly*, 10 Cal. 3d 565, 516 P.2d 875, 883, 111 Cal. Rptr. 171, 179 (1973).

⁵⁸ See, e.g., *Fitts v. United States*, 484 F.2d 108, 113 (10th Cir. 1960); *People v. Kelly*, 10 Cal. 3d 565, 516 P.2d 875, 882-83, 111 Cal. Rptr. 171, 178-79 (1973); *Dubs v. State*, 2 Md. App. 524, 235 A.2d 764, 776 (1967); *State v. Shipman*, 568 S.W.2d 947, 951 (Mo. Ct. App. 1978); *State v. Maik*, 60 N.J. 203, 287 A.2d 715, 722 (1972); VAND. Special Project, *supra* note 3, at 1198.

Thus, in *Commonwealth v. Sheehan*, 376 Mass. 765, 383 N.E.2d 1115, 1119 (1978), the court held that "if the consumption of drugs causes a mental disease or defect apart from drug addiction itself, normally the defendant may rely on that mental disease or defect in support of his assertion of his lack of criminal responsibility, even if the defendant's drug consumption was voluntary." In *Green v. United States*, 383 F.2d 199, 201 (D.C. Cir. 1967), cert. denied, 390 U.S. 961 (1968), the D.C. Circuit agreed, noting that "[t]here may well be some cases where prolonged and extensive use of narcotics has substantially impaired the capacity to control behavior, and a 'mental disease' within our *McDonald* standard may result." And in *Brinkley v. United States*, 498 F.2d 505, 511 (8th Cir. 1974), the Eighth Circuit chided the District Court for underestimating "the unique and potentially dangerous impact that prolonged use of LSD appears to have on the psychological state and behavioral patterns of some users."⁵⁹

⁵⁹ See also *Watson v. United States*, 439 F.2d 442, 460 (D.C. Cir. 1970) (Bazelon, C.J., concurring in part and dissenting in part); *United States v. Ingman*, 426 F.2d 973, 977 (9th Cir. 1970); *Gaskins v. United States*, 410 F.2d 987, 989 (D.C. Cir. 1967); *Hutcherson v. United States*, 345 F.2d 964, 970 (D.C. Cir.) (Burger, J., concurring), cert. denied, 382 U.S. 894 (1965); *Perkins v. United States*, 228 F. 408, 415 (4th Cir. 1915); *State v. Valenzuela*, 114 Ariz. 81, 559 P.2d 201, 204 (1977); *People v. Kelly*, 10 Cal. 3d 565, 516 P.2d 875, 883, 111 Cal. Rptr. 171, 179 (1973); *People v. King*, 181 Colo. 439, 510 P.2d 333, 335 (1973); *People v. Penman*, 271 Ill. 82, 110 N.E. 894 (1915); *People v. Peters*, 33 Ill. App. 3d 284, 337 N.E.2d 716, 723 (1975); *People v. Jackson*, 116 Ill. App. 2d 304, 253 N.E.2d 527, 530 (1969); *Faught v. State*, 162 Ind. App. 436, 319 N.E.2d 843, 848 (1974); *Dubs v. State*, 2 Md. App. 524, 235 A.2d 764, 776 (1967); *State v. Crayton*, 354 S.W.2d 834, 837 (Mo. 1962); *State v. Shipman*, 568 S.W.2d 947, 950 (Mo. Ct. App. 1978); *State v. Maik*, 60 N.J. 203, 287 A.2d 715, 722 (1972); *People v. Borrero*, 19 N.Y.2d 332, 227 N.E.2d 18, 20, 280 N.Y.S.2d 109 (1967); *State v. Gaines*, 40 Ohio App. 2d 224, 318 N.E.2d 857, 865 (1974). Cf. *United States v. Hall*, 583 F.2d 1288 (5th Cir. 1978)

Other courts have admitted evidence of a defendant's addiction on the ground that it constitutes "some evidence" of mental illness, *Heard v. United States*, 348 F.2d 43, 46 n.6 (D.C. Cir. 1964) (per curiam), or that addiction, when combined with other circumstances, may constitute a mental disease or defect. As the court observed in *Gaskins v. United States*, 410 F.2d 987, 993 (D.C. Cir. 1967), "any factor or group of factors—including narcotic addiction and barring only '[n]arcotic addiction, without something more'—which met the test for insanity would suffice to immunize appellant from conviction." See also *id.* at 989.⁶⁰ Finally, the relevance

(admitting expert testimony that chronic alcoholism caused insanity); *Fitts v. United States*, 284 F.2d 108, 113 (10th Cir. 1960) (same).

A defendant who takes drugs knowing that they are likely to cause a mental disease or defect, however, has no defense. See *Perkins v. United States*, 228 F. at 415; *Commonwealth v. Sheehan*, 376 Mass. 765, 383 N.E.2d 1115, 1119 (1978); *Demouchette v. State*, 502 S.W.2d 712, 715 (Tex. Crim. App. 1973); cf. *Kane v. United States*, 399 F.2d 730 (9th Cir. 1968), *cert. denied*, 393 U.S. 1057 (1969) (same re alcohol).

Moreover, some courts may refuse to recognize an insanity defense where the defendant's mental disease or defect is brought about by voluntary, rather than involuntary, drug use, cf. *United States v. Burnim*, 576 F.2d 236, 238 (9th Cir. 1978) (insanity brought about by voluntary intoxication is no defense), or where voluntary drug use results in only temporary rather than a more lasting insanity, see, e.g., *State v. Valenzuela*, 559 P.2d at 204; *People v. Penman*, 110 N.E. at 900; *State v. Hall*, 214 N.W.2d 205, 207-08 (Iowa 1974). These cases are not directly relevant here, however, because they involve defendants who claimed that their one-time use of drugs resulted in insanity, rather than addicts who claimed that their long-term, habitual drug use caused a mental disorder. Moreover, in this case defendant does not rely on the concept of temporary insanity.

⁶⁰ See also *United States v. Freeman*, 357 F.2d 606, 625 (2d Cir. 1966); *Heard v. United States*, 348 F.2d 43, 44 (D.C. Cir. 1964) (per curiam). Cf. *State v. Matthews*, 20 Or. App. 466, 532 P.2d 250, 254 (1975) (combined effects of alcoholism and moderate organic brain damage could rise to insanity).

of evidence regarding a defendant's drug addiction has been so clear to many other courts that they have routinely admitted it on the question of the defendant's sanity without comment or without indicating their rationale.⁶¹

In sum, evidence of a defendant's drug dependence should not automatically be excluded in support of an insanity defense. Although that dependence may not itself constitute a mental disease or defect, evidence of addiction may be relevant to the question of sanity in a number of respects and should therefore be admitted in such cases.⁶² Such an approach is consistent with this

⁶¹ See, e.g., *Watson v. United States*, 439 F.2d 442, 450 (D.C. Cir. 1970) (en banc) (evidence of insanity, which included evidence of addiction, sufficient to raise jury question); *Greene v. United States*, 352 F.2d 366, 367 (D.C. Cir. 1965) (per curiam); *Brown v. United States*, 331 F.2d 822, 823 (D.C. Cir. 1964) (per curiam) (defendant entitled to assistance to develop defense of insanity based on addiction); *Rivers v. United States*, 330 F.2d 841, 841 (D.C. Cir. 1964) (per curiam) (evidence that defendant was an addict "who also suffered from a mental disease related to the commission of the offenses by reason of his addiction" sufficient to raise jury question); *Horton v. United States*, 317 F.2d 595, 596 (D.C. Cir. 1963) (per curiam) (evidence of insanity, which included evidence of addiction, sufficient to raise jury question); *United States v. Mason*, 277 F. Supp. 114, 116 (W.D. Mo. 1967); *McLaughlin v. State*, 236 Ga. 577, 224 S.E.2d 412, 413 (1976); *Greenleaf v. State*, 7 Md. App. 575, 256 A.2d 552, 553 (1969); *Commonwealth v. Sheehan*, 376 Mass. 765, 383 N.E.2d 1115, 1120 n.7 (1978) (dictum).

⁶² The portion of this Court's insanity test providing that the term "mental disease or defect" does not include "an abnormality manifested *only* by repeated criminal or otherwise antisocial conduct" does not militate against adopting the approach suggested by *amicus*. *Blake v. United States*, 407 F.2d 908, 916 (5th Cir. 1969) (en banc) (emphasis added). A defendant who establishes only his addiction to narcotics is not, in *amicus*' view, entitled to acquittal; he must also establish that he suffers from a mental disease or defect that may be related to his addiction.

Court's admonition in *Blake v. United States*, 407 F.2d 908, 911 (5th Cir. 1969) (en banc), that courts should follow

the salutary principle, applicable in cases involving the defense of insanity, of admitting all evidence, both lay and expert, in any wise relevant or pertinent, to the issue of sanity. This is in keeping with the philosophy of letting in all facts which might be helpful to the jury in making the final determination of the criminal responsibility of the accused.⁶³

III. The Scientific Evidence Supports Defendant's Argument that Drug Addiction Affects the Capacity to Conform One's Conduct to the Requirements of Law.

The second prong of the ALI's Model Penal Code definition of insanity as adopted by this Court requires proof that at the time of the crime the defendant "lack[ed] substantial capacity . . . to conform his conduct to the requirements of law." *Blake v. United States*, 407 F.2d 908, 916 (5th Cir. 1969) (en banc). Although all researchers in the field may not agree that addiction renders an individual substantially unable to conform to the law, there is significant agreement that addiction does have a profound impact on behavior and exercises a compulsive influence to some extent. Accordingly, evidence of addiction should be admitted as proof of the volitional component of this Court's definition of insanity.

⁶³ See also *Faught v. State*, 162 Ind. App. 436, 319 N.E.2d 843, 845 (1974); *Faught v. State*, 155 Ind. App. 520, 293 N.E.2d 506, 508 (1973); *State v. Gilmore*, 242 Or. 463, 410 P.2d 240, 242 (1966) ("With the issue and the evidence incapable of precise measurement, any finding on any aspect of the defendant's mental condition would be relevant and of assistance to the jury in reaching its most difficult decision."); VAND. Special Project, *supra* note 3, at 1189-90.

As discussed in Part I, *supra*, an individual who is psychologically dependent on narcotics continues to use drugs because of his belief that they are necessary to produce pleasure or avoid discomfort. A psychologically dependent user "develops a psychological need or craving which he is probably powerless to ignore" Bowman, *Narcotic Addiction and Criminal Responsibility Under Durham*, 53 Geo. L.J. 1017, 1036 (1965). Similarly, those who are physically dependent on narcotics are motivated to continue taking drugs to avoid withdrawal. Researchers have concluded that physical dependence "leads to continuity of intoxication with resultant subservience of all phases of the addict's life to the one aim of obtaining and maintaining a constant supply of the drug." Isbell & White, *Clinical Characteristics of Addiction*, 14 Am. J. Med. 558 (1953). "When impairment is severe, the individual's life can become totally dominated by use of the substance" American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 164 (3d ed. 1980); see also *id.* at 172 (defining opiate dependence as including an "inability to reduce or stop use . . .").

Thus, researchers agree that addiction is characterized by a loss of self-control and that an addict will go to great lengths to secure a supply of drugs. His desire to continue taking drugs is "frequently stronger than any other desire the addict has known." O. Ray, *Drugs, Society, and Human Behavior* 202 (1972). Accordingly, he "will do whatever he can to maintain his protected state." S. Peele, *The Science of Experience: A Direction for Psychology* 85 (1983). "In susceptible persons [narcotics] produce a pathological hunger of such intensity that the drive for narcotics displaces all other

responsibilities." Dole, *Biochemistry of Addiction*, 39 *Ann. Rev. of Biochemistry* 821 (1970).⁶⁴

A number of courts have agreed, characterizing the drug-using and drug-seeking behavior of addicts as compulsive and beyond their control. Thus, the court noted in *Castle v. United States*, 347 F.2d 492 (D.C. Cir. 1964), *cert. denied*, 381 U.S. 929, 953 (1965), that addiction causes "an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means." *Id.* at 493 (quoting World Health Organization, *Technical Report No. 2*, at 6 (1950)). Another court observed that "the inordinate use of a narcotic drug tends to create an irresistible craving and forms a habit for its continued use until one becomes an addict, and he respects no convention or obligation and will lie, steal, or use any other base means to gratify his passion for the drug, being lost to all considerations of duty and social position." *People v. Jaurequi*, 142 Cal. App. 2d 555, 298 P.2d 896, 900 (1956) (emphasis added).⁶⁵ And some courts have noted that imprisoning addicts, whose use of narcotics and drug-seeking behavior

⁶⁴ See also E. ABEL, *supra* note 4, at 115; R. JULIEN, *supra* note 3, at 108, 111; Bowman, *supra* note 7, at 1038; Felix, *supra* note 31, at 465; VAND. Special Project, *supra* note 3, at 1198-99.

⁶⁵ See also *Robinson v. California*, 370 U.S. 660, 671 (1962) (Douglas, J., concurring); *Watson v. United States*, 439 F.2d 442, 460 (D.C. Cir. 1970) (Bazelon, C.J., concurring in part and dissenting in part); *Hightower v. United States*, 325 F.2d 616, 620 (D.C. Cir. 1964) (Fahy, J., dissenting), *cert. denied*, 384 U.S. 994 (1966); *In re Foss*, 10 Cal. 3d 910, 519 P.2d 1073, 1079 n.5, 112 Cal. Rptr. 649, 655 n.5 (1974); *Prather v. Commonwealth*, 215 Ky. 714, 287 S.W. 559, 560 (1926); *State v. Gilchrist*, 15 Wash. App. 892, 552 P.2d 690 (1976); Bennett, *supra* note 29, at 183, 194. Cf. *Powell v. Texas*, 392 U.S. 514, 551 & n.3 (1968) (White, J., concurring in the result) (alcoholic is compelled to drink); *id.* at 1287 (Fortas, J., dissenting) (same); *People v. Wyatt*, 22 Cal. App. 3d 671, 99 Cal. Rptr. 674, 678 (1972) (same); *State v. Fearon*, 283 Minn. 90, 166 N.W.2d 720, 724 (1969) (same).

is beyond their control, does not serve to deter such behavior.⁶⁶

Congress has also acknowledged the effects of drug dependence on an addict's life. The Narcotic Addict Rehabilitation Act of 1966, 28 U.S.C. § 2901(a), recognized that an addict may be "so far addicted to the use of such narcotic drugs as to have lost the power of self-control with reference to his addiction." In addition, a Senate committee observed that there is a "hard core" of "chronic and incurable drug addicts who, in reality, have lost their power of self-control." S. Rep. No. 2033, 84th Cong., 2d Sess. 8 (1956).

Some researchers, however, downgrade the effects of drug dependence on an addict's behavior and self-control. They argue that drug use and drug-seeking behavior by addicts have not been proven to be involuntary by any scientific measurement. Instead, the addict's behavior has merely been presumed to be compelled on a *post hoc* theory based on observations that addicts tend to engage in certain behavior. See H. Fingarette & A. Hasse, *Mental Disabilities and Criminal Responsibility* 170-71, 191 (1979). Other researchers point out that the behavior of addicts is remarkably varied. Some are better able to

⁶⁶ See, e.g., *Robinson v. California*, 370 U.S. 660, 674 n.2 (1962) (Douglas, J., concurring); *In re Foss*, 10 Cal. 3d 910, 519 P.2d 1073, 1082, 112 Cal. Rptr. 649, 658 (1974). See also C. KORNITSKY, *supra* note 4, at 190; Bennett, *supra* note 29, at 182-83; Bowman, *supra* note 7, at 1017-18 n.4; Chamblis, *Types of Deviance and the Effectiveness of Legal Sanctions*, 1967 WIS. L. REV. 703, 712-13; Chayet, *Legal Aspects of Drug Abuse*, 3 SUFFOLK U.L. REV. 1, 1 (1968); VAND. Special Project, *supra* note 3, at 1190-91. Cf. *Powell v. Texas*, 392 U.S. 514, 564 (1968) (Fortas, J., dissenting) (jailing chronic alcoholic has no deterrent effect); *State v. Fearon*, 283 Minn. 90, 166 N.W.2d 720, 725 (1969) (same); Case Comment, *Criminal Law: Chronic Alcoholism as a Defense to Crime*, 61 MINN. L. REV. 901, 915 (1977) (hereinafter cited as MINN. Case Comment) (same).

exercise self-control than others, depending on "the personal characteristics of the user, his expectations about the drug experience and about society's attitudes and possible responses, the setting in which the drug is used, as well as broad socio-cultural factors" National Commission on Marijuana and Drug Abuse, *Drug Use in America: Problem in Perspective* 119 (Second Report, March 1973). For example, some addicts who are socially or financially able to obtain a supply of narcotics may be able to maintain their health, continue working, avoid criminal prosecution, and suffer little incapacitation as a result of their habit. See, e.g., R. Julien, *A Primer of Drug Action* 117 (3d ed. 1981); Jaffe, *Drug Addiction and Drug Abuse*, in *The Pharmacological Basis of Therapeutics* 284, 294 (L. Goodman & A. Gilman 5th ed. 1975).⁶⁷ What may be compelling, therefore, is the addict's desire to obtain drugs, not to engage in illegal behavior. But those who do not have the financial means to obtain drugs without discovery may be forced by their drug dependence to engage in illegal behavior in order to satisfy their craving.⁶⁸

Some courts have not agreed, refusing to find that an addict was compelled by his drug dependence to engage in criminal conduct. For example, in *Bailey v. United States*, 386 F.2d 1, 4 (5th Cir. 1967), *cert. denied*, 392 U.S. 946 (1968), this Court observed, though without citing any support, "[i]t would appear that an element

⁶⁷ See also Blum, *supra* note 3, at 57.

⁶⁸ Although the rate of drug addiction may, therefore, be associated with the incidence of property crimes, it is not correlated with the incidence of violent crimes because individuals on opiates are usually quiet, passive, and seldom prone to violence. See, e.g., R. JULIEN, *supra* note 3, at 117; C. KORNETSKY, *supra* note 4, at 203; TASK FORCE ON NARCOTICS AND DRUG ABUSE, TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE 10 (1967); Bowman, *supra* note 7, at 1040-41; Jaffe, *supra* note 7, at 295; Robins, *supra* note 21, at 328; VAND. Special Project, *supra* note 3, at 1160.

of reasoned choice yet exists when an addict knowingly violates the law in acquiring and using drugs." Likewise, in *Watson v. United States*, 439 F.2d 442, 451 (D.C. Cir. 1970) (en banc), the court characterized drug addiction as a "condition[] from which it is still widely assumed, rightly or wrongly, that the victim retains some capacity to liberate himself."⁶⁰

Although all researchers have not agreed on the precise impact of narcotics on one's behavior controls, there is substantial agreement that drug dependence does have a powerful influence on behavior and that discontinuing drug use is exceedingly difficult. Expert testimony about the effect of addiction on a defendant's ability to conform his conduct to legal requirements should therefore be admitted in cases—like this one—where the defendant is charged with illegal use or possession of narcotics or with criminal conduct aimed at acquiring narcotics to satisfy his habit. The absence of consensus in the scientific literature may affect the weight given the defendant's evidence, but it should not preclude its admissibility.

⁶⁰ See also *United States v. Coffman*, 567 F.2d 960, 963 (10th Cir. 1977); *United States v. Moore*, 486 F.2d 1139, 1149-50 (D.C. Cir.) (opinion of Wilkey, J.), cert. denied, 414 U.S. 980 (1973); *State v. Smith*, 219 N.W.2d 655, 656 (Iowa 1974); *State v. White*, 27 N.J. 158, 142 A.2d 65, 68 (1958); *Loveday v. State*, 74 Wis. 2d 503, 247 N.W.2d 116, 122 (1976). Cf. *Powell v. Texas*, 392 U.S. 514, 535, 530 (1968) (plurality) (alcoholics are not "utterly unable to control" their urge to drink and criminal sanctions for public drunkenness have a deterrent effect); *id.* at 539 (Black, J., concurring) (same); *id.* at 559 n.2 (Fortas, J., dissenting) (suggesting that crimes such as theft are not a characteristic and involuntary part of alcoholism).

Another court observed that an addict's drug-seeking behavior is compelled only when he is actually undergoing withdrawal. See *United States v. Carter*, 436 F.2d 200, 202 (D.C. Cir. 1970) (per curiam). There the court rejected the defendant's insanity defense because he offered no proof that at the time of the crime he was suffering from withdrawal. See also *Heard v. United States*, 348 F.2d 43, 45-46 (D.C. Cir. 1964) (per curiam). But see note 70 *infra* and accompanying text.

See, e.g., *United States v. Baller*, 519 F.2d 463, 466 (4th Cir.), cert. denied, 423 U.S. 1019 (1975).

Such evidence will help enable the trier of fact to determine the extent to which the defendant's behavioral controls were impaired, which will depend in large part on the extent of the defendant's dependence. The greater the degree of dependence, the greater the compulsion to continue using drugs and to obtain an adequate supply of drugs by any available method. See *Bowman*, *supra*, at 1047. If the defendant used drugs simply to flout authority or to satisfy a mere desire, he may reasonably have been expected to seek treatment and may, therefore, have had a substantial capacity to conform to legal requirements. But if he was so dependent on narcotics that he could not reasonably have been expected to take steps to cure his dependence, he may not have had a substantial capacity to conform to the law.⁷⁰

This approach—admitting evidence regarding the effect of the defendant's drug dependence on his behavioral controls and leaving its weight to the jury—is consistent with the practice of most courts, including those that have not adopted the view that the behavior of addicts is involuntary.⁷¹ It is also consistent with the instruction

⁷⁰ The defendant should not be required to establish that he was undergoing withdrawal at the time of the crime. Because the addict's need for narcotics is constant, he should not reasonably be expected to wait until withdrawal symptoms are actually felt before he acts to secure an additional supply of narcotics. See *Bowman*, *supra* note 7, at 1044. The trier of fact might conclude, however, that a defendant who already had a supply of drugs sufficient to satisfy his own habit and who attempted to obtain an additional quantity intended not to use those drugs himself but to supply others. In such cases, where the criminal conduct was not related to the defendant's personal use of narcotics, he would have no excuse.

⁷¹ See, e.g., *United States v. Bass*, 490 F.2d 846, 850 (5th Cir. 1974); *United States v. Collins*, 433 F.2d 550, 553 (D.C. Cir. 1970); *Gaskins v. United States*, 410 F.2d 987, 989 (D.C. Cir. 1967);

given by this Court in *Blake v. United States*, 407 F.2d 908, 911 (5th Cir. 1969) (en banc), and quoted above, that evidence on the question of sanity should be liberally admitted to assist the factfinder in evaluating the responsibility of the defendant.

CONCLUSION

In light of the scientific literature, *amicus* urges that evidence of addiction not be excluded automatically in all cases when offered in support of an insanity defense, and that the question whether a drug-dependent defendant is criminally responsible be answered on a case-by-case basis.⁷² *Amicus* does not argue that addicts are entitled to acquittal by reason of insanity in all cases, or that proof of addiction is by itself sufficient to establish an insanity defense. In some cases, a defendant's drug dependence may not be related to psychological factors or associated with an underlying mental disease. In others, a defendant's addiction may not substantially affect his ability to exercise self-control, or the crime with which he is charged may not be related to those aspects of his behavior that are affected by addiction, *i.e.*, drug-using and -seeking behavior. In such cases, evidence of addiction may properly be excluded as irrelevant to the question of sanity.

The policy considerations relied on by the District Court do not militate against adoption of the limited

Heard v. United States, 348 F.2d 43, 45 (D.C. Cir. 1964) (per curiam); *Fisher v. State*, 54 Del. 542, 182 A.2d 333, 334 (1962); *McLaughlin v. State*, 236 Ga. 577, 224 S.E.2d 412, 414 (1976); *People v. Jackson*, 116 Ill. App. 2d 304, 253 N.W.2d 527, 532 (1969); *State v. Crayton*, 354 S.W.2d 834, 836 (Mo. 1962); *State v. White*, 27 N.J. 158, 142 A.2d 65, 67 (1958); *State v. Flores*, 82 N.M. 480, 483 P.2d 1320, 1321 (N.M. Ct. App. 1971); *State v. Matthews*, 20 Or. App. 466, 532 P.2d 250, 252 (1975). But see *State v. Smith*, 219 N.W.2d 655, 656 (Iowa 1974).

⁷² See, *e.g.*, Bowman, *supra* note 7, at 1048; MINN. Case Comment, *supra* note 66, at 917.

approach suggested by *amicus*. Because *amicus* would not have the Court afford all addicts a defense, the "flood-gates" would not be opened, leading to acquittals in numerous criminal cases where the defendant is dependent on narcotics. For the same reason, *amicus*' approach would not exempt addicts from the federal criminal narcotics laws and, therefore, would not conflict with the Narcotic Addict Rehabilitation Act of 1966, 28 U.S.C. § 2901 *et seq.* Congress' intent in enacting that statute was to require civil commitment rather than prosecution and imprisonment for those selected narcotics addicts who are considered "likely to be rehabilitated through treatment" *Id.* § 2902(a). By implying that some addicts may be prosecuted, the Act may prohibit courts from acquitting all drug-dependent defendants. *See, e.g., Bailey v. United States*, 386 F.2d 1, 4 (5th Cir. 1967), *cert. denied*, 392 U.S. 946 (1968). But it does not indicate Congress' intent to preclude addicts who are prosecuted from advancing any applicable defense, including the insanity defense, or to prohibit courts and juries from acquitting addicts who qualify under the legal definition of insanity. Accordingly, the approach urged in this brief does not "'stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Fidelity Federal Savings & Loan Ass'n v. de la Cuesta*, 102 S. Ct. 2266 (1982) (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)).

Should the Court adopt the position suggested by *amicus* and permit the introduction of evidence of addiction in appropriate cases, the Court could limit its holding to the facts of this case, that is, to the few cases where the defendant is an iatrogenic addict or otherwise acquired his drug dependence accidentally or involuntarily. Although such persons are arguably less culpable because they did not voluntarily become addicted, there

is no evidence that their dependence, once acquired, differs in any material respect from that of addicts who became dependent voluntarily. Thus, no compelling rationale seems to justify treating voluntary and involuntary addicts differently in terms of the admissibility of evidence of addiction when offered in support of an insanity defense.⁷³

Because evidence of addiction may be relevant to the questions whether a defendant has a mental disease or defect and whether, as a result of that disorder, he lacked substantial capacity to conform to legal requirements, the District Court erred in excluding the evidence of addiction proffered by defendant on the ground that addiction by itself does not constitute insanity. Accordingly, *amicus* urges the Court to reverse the District Court's order excluding that testimony and to remand for a new trial.

Respectfully submitted,

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⁷³ See, e.g., Supplemental Brief for the United States at 33-34; *Prather v. Commonwealth*, 215 Ky. 714, 287 S.W. 559, 560 (1926); Jaffe, *supra* note 7, at 293; but cf. *Commonwealth v. Sheehan*, 376 Mass. 765, 383 N.E.2d 1115, 1119 n.6 (1978) (dictum).

CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of November, 1983, I served the foregoing Brief of *Amicus Curiae* American Psychological Association in Support of Appellant by mailing copies, first-class postage prepaid, to Julian R. Murray, Jr., Esquire, Murray, Murray, Ellis, Braden & Landry, 612 Gravier Street, New Orleans, Louisiana 70130, counsel for appellant, and to Harry W. McSherry, Esquire, Assistant United States Attorney, Hale Boggs Federal Building, 500 Camp Street, New Orleans, Louisiana 70130, counsel for appellee.

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