CASE REPORT

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New Perspectives in the Legal Psychiatry of Cocaine-Related Crimes

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ABSTRACT: The legal criteria for the insanity defense as it applies to cocaine-related crimes remains elusive because of cocaine's unique spectrum of effects on human thought and action. This paper discusses the literature relevant to cocaine and forensic psychiatry/psychology, and summarizes the results of a survey of forensic psychiatrists on the topic of drug-induced psychosis. A conceptual framework is posited for the expert witness to distinguish the separable effects of cocaine on human behavior and to clarify their relationship to criminal responsibility.

KEYWORDS: psychiatry, cocaine, jurisprudence, crack

The cocaine and crack epidemic has reached an alarming level. Nowhere is the impact felt more severely than the legal system, where the courts and prisons are overwhelmed with cocaine-related cases. Of particular interest to the author is the interface of psychiatry with the criminal law, and the role of the forensic psychiatrist in assisting the justice system.

Statutory and common law precedents relating to addiction have a long history. However, because of the particular nature of cocaine and its specific effects upon one's mental state, cocaine-related crimes are frequently presenting new and unique fact patterns that make decisions for legal experts more complicated.

Although there has been one previous report published [*1*] on the subject of cocaine and the legal system, scant attention has been paid to the details of how cocaine-related criminal cases are now being handled by legal professionals as well as expert witnesses. The purpose of this paper is to focus on this issue, and to recommend guidelines for the expert witness in organizing information and formulating conclusions on these matters.

This report is divided into four main sections. First, the social-scientific historical precedents and conceptual issues are reviewed with regard to addiction in general and, more specifically, cocainism. Next, data from a survey[2] of forensic psychiatrists on the

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The contents of this paper will be included in sections of a more comprehensive report being prepared for publication in collaboration with Lawrence Siegal, M.D., Department of Psychiatry, New York Medical College, Valhalla, NY.

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[2]The data from this survey were provided by Lawrence Siegal, M.D.

subject of drug psychosis and the insanity defense is provided. Third, the legal logic involving cocaine-related charges in the context of a standardized and systematic strategy for formulating opinions about psychiatric-legal cases is discussed. Finally, the dilemma of the cocaine-using defendant with a coexisting or superimposed psychiatric disorder is discussed with regard to forensic psychiatry, and a case example is described in order to illustrate principles.

Social Versus Scientific Issue

Prosecuting the cocaine addict accused of a crime raises many difficult, complicated social, ethical, and scientific questions. The precise nature of addiction cannot be strictly defined in scientific terms. Additionally, the level of volitional control that an individual has over an addiction is the subject of vigorous and ongoing scientific and philisophical debate. Therefore, the personal responsibility attributed to an individual with regard to criminal behavior while seeking, acquiring, or being intoxicated with cocaine remains a disputable issue.

Many controversial theories have been posited to explain the phenomenon of addiction. Perhaps the most popular theory of the day among addiction treatment professionals is "the disease concept." Essentially stated, "the disease concept" espouses that an addiction is a disease for which the individual has no control; however, they may be considered responsible for taking the steps necessary for managing their disease. Prominent social theorists [2,3] have attacked "the disease concept," arguing that it negates a causal link between individual and social responsibility and the grave problem of drug addiction.

Most professionals in the field of addiction treatment would agree that an individual who is addicted to cocaine may have control over drug-seeking behavior under certain circumstances, and may lose volitional control over compulsive drug-seeking under different circumstances. Of greater controversy is whether during periods of intoxication an individual may be prone to certain uncontrollable compulsive criminal acts, or may have contextually dependent diminished capacity. The arduous task for the expert witness and the court of law is to determine where the line should be drawn in various individual cases; that is, for what circumstances should an addicted individual be held fully culpable, partially responsible, or exculpated?

Jurisprudence applied to the issue of addiction and criminal responsibility has a history dating back to the 18th century. Recently, the two landmark Supreme Court decisions of *Robinson v. California* (1962) and *Powell v. Texas* (1968) have set some contemporary judicial precedents which help to set standards in the legal matter of addiction and criminal responsibility. In the former case, it was held that an individual could not be prosecuted solely for being an addict, even to an illegal substance, that is, that addiction to any substance is an illness and therefore cannot be justifiably criminalized. Such punishment would be considered a violation of an individual's Eighth Amendment constitutional right, that is, protection from cruel and unusual punishment. In the latter case, it was held that behavior blatantly indicative of intoxication (with alcohol) in a public setting could rightfully be deemed criminal, and that this act is subject to at least some volitional control. There have since been many related cases with important variations that have underscored the problematic dilemma of determining whether an act is a willful and illegal misconduct, or rather a direct or indirect correlate of a disease.

Of great import in the judicial decision-making is the timeless problem of balancing the best interests of the society with the best interests of the individual. In the face of the disastrous effects of the cocaine epidemic in the United States, it is necessary that firm legally sanctioned limits be set and enforced with regard to cocaine-related criminal behavior. It is also necessary that reasonable provisions be made for rehabilitation of the cocaine addict charged with or convicted of a crime. Leniency with regard to the

criminal responsibility of cocaine-related crimes may enable cocaine addicted individuals to continue their drug habit, as well as alienating other members of society to those afflicted with addiction. Conversely, intolerance or strict liability applied to cocaine-related crimes may obstruct the rehabilitative process for those who have a potential for recovery, as well as alienating many members of society to the law enforcement efforts targeted at controlling the cocaine epidemic. Clinicians in the field of addictions often refer to the terms "enabling" and "restricting," meaning that people or systems can "enable" an addict to continue to use drugs, or conversely can "restrict" an addict from obtaining treatment.

The relationship between cocaine and the criminal law is relevant to several distinct legal issues: not guilty by reason of insanity, guilty but mentally ill, diminished capacity, extreme emotional distress, and mens rea. Many of the legal precedents established for addiction-related behaviors involve the use or intoxication with alcohol. Cocaine, and particularly the new form "crack," however, are a very different class of drugs and have unique properties which raise new and more complicated legal issues.

Survey

A survey[3] was designed to assess the legal statutory and case precedents that apply on a state level to the issue of the insanity defense and drug-induced psychosis. A brief questionnaire was forwarded to two forensic psychiatrists (members of the American Academy of Psychiatry and the Law) in each state and Washington D.C. (a total of 102). Sixty-four forensic psychiatrists responded to the survey.

Forty-five (70% of respondents) of the forensic psychiatrists reported they had no experience, nor were they aware of any statutes or case law in their state covering the specific issue of drug-induced psychosis and the insanity defense. State by state, the data (n = 1 or n = 2) for these 45 psychiatrists is as follows:

Alaska (n = 1), Alabama (n = 1), Arkansas (n = 1), Arizona (n = 2), California (n = 1), Colorado (n = 1), Delaware (n = 2), Hawaii (n = 1), Iowa (n = 2), Idaho (n = 1), Indiana (n = 2), Kansas (n = 1), Kentucky (n = 1), Louisiana (n = 1), Massachusetts (n = 1), Maryland (n = 2), Maine (n = 1), Michigan (n = 2), Minnesota (n = 2), Missouri (n = 1), Nebraska (n = 1), New Mexico (n = 1), Nevada (n = 1), Ohio (n = 1), Oklahoma (n = 1), Pennsylvania (n = 1), Rhode Island (n = 1), South Carolina (n = 1), Tennessee (n = 2), Texas (n = 1), Virginia (n = 1), Vermont (n = 2), Washington (n = 1), Wisconsin (n = 1), Wyoming (n = 1), D.C. (n = 1).

Nineteen (30% of respondents) did cite cases or statutes that applied to the issue. Forensic psychiatrists in the following states reported some statutory or case law relevant to the issue:

Alabama (n = 1), California (n = 1), Connecticut (n = 2), Florida (n = 1), Hawaii (n = 1), Illinois (n = 2), Maine (n = 1), North Carolina (n = 2), North Dakota (n = 2), Ohio (n = 1), Oregon (n = 1), South Carolina (n = 1), Virginia (n = 1), Wisconsin (n = 1), West Virginia (n = 1).

Most of the cases were resolved on the basis of the application of the American Law Institute (ALI) or McNaughten insanity defense to the fact pattern. Generally, the cited statutes addressed the separate issues of voluntary intoxication and the insanity defense, but were open to interpretation when applied to the issue of drug-induced psychosis or the mentally ill/chemically abusing (MICA) patient; that is, no specific statutes addressed the issue of drug-induced psychosis and criminal responsibilty. A California statute, however, was forwarded which regarded the voluntary intoxication rule applicable to all

[3]Data provided by Lawrence Siegal, M.D.

drug-induced acts, in effect eliminating drug-induced psychosis as an insanity defense in that state. Remarked one Florida forensic psychiatrist, "although the intoxication defense is frequently tried (in Florida), it is seldom successful."

It is clear from the data of this survey that the majority of forensic psychiatrists in various states may not yet have extensive experience with cocaine- or "crack"-related crimes. However, if the cocaine/crack epidemic continues along its present course, there will be an ever-increasing need to examine the psychiatric-legal issue of cocaine-induced psychosis and criminal responsibility.

Fourfold Path

Analyzing the inextricable web of psychiatric and legal data in many cocaine-related criminal cases can be a painstaking process. Rosner [*4*] has defined a four-step process with which the forensic psychiatrist can organize the clinical information and present it in a context that is clear and useful to the courts and legal professionals. The "fourfold path" includes: stating the legal issue, defining the legal standards, presenting the clinical psychiatric data, and, finally, applying these data to the legal standards in order to formulate conclusions about the legal issue.

With regard to cocaine-related crimes, the legal standards are often ill-defined. The voluntary intoxication rule associated with alcohol-related crimes is not universally accepted as a commensurate standard applied to acts committed during cocaine-induced psychosis. Furthermore, if an underlying predisposition to psychosis can be demonstrated for an individual, the voluntary intoxication rule cannot be clearly interpreted. Although it is generally agreed that voluntary intoxication does not mitigate criminal responsibility, the defendant's mental state at the time of commission of the act will depend on many different factors. In the final analysis, the presentation of various influencing factors in any individual case will largely determine the outcome of psychiatric-legal defenses for defendants with a history of cocaine use [*5*].

Mitchell [*6*] stipulates three basic alternatives available to the legal system for proceeding with criminal defenses related to drug-induced intoxication: to deny a mitigating role to intoxication, even if mes rea is absent, that is, strict liability; to create a separate offense of being intoxicated and dangerous; or to inquire directly into whether or how the intoxication affected the person's mental state at the time of the offense. Mitchell [*6*] favors the latter alternative, which is consistent with the legal reasoning inherent in previous phencyclidine or "PCP"-related cases [*7*]. Various psychiatric-legal defenses are now being tested in courts for cocaine- and "crack"-related crimes. However, there is wide controversy among both legal and medical professionals with respect to the method of inquiry into how cocaine intoxication may affect one's mental state at the time of a crime.

Mentally Ill Cocaine Abusers

The relationship between cocaine, psychosis, violence, and psychiatric illness has been the subject of many scientific investigations. The difficulty in establishing, on a scientific basis, a clearly defined association between cocaine use and specific psychotic or violent behaviors is that these phenomenon are multifactorial in nature. However, an overall conceptual framework for understanding these complex interrelationships can be constructed. The important principles to consider are: the time frame of cocaine's effects, that is, acute versus long-term effects of cocaine intoxication; the individual's underlying predisposition to psychosis or psychiatric illness; the individual's personality; and the disinhibiting or "unmasking" effect of the drug with regard to behavior. Let us consider these principles in sequence.

It has been observed that acute intoxication with cocaine or "crack" can frequently produce agitation, hyperactivity, restlessness, excitement, or paranoia [*8*]. These symptoms are dose dependent and can occur in cocaine users without any psychiatric history, although those who are more predisposed to psychosis are likely to be more sensitive to cocaine's psychotomimetic effects. Cocaine-induced symptoms to some degree may be idiosyncratically determined, but the appearance of psychotic symptoms is usually associated with continued escalating use of cocaine [*9*]. While cocaine addicts commonly deny the severity of their problem and resist treatment, they are usually aware that their cocaine abuse is wrong as well as illegal. The level of control that they maintain during the evolution of their addiction is a subject of heated controversy. However, some degree of responsibility for attempting to seek and be compliant with treatment is usually attributed to the individual. This is consistent with various theories of addiction, including the "disease concept" behavioral and social theories.

The coexistence of a major psychiatric disorder and cocaine dependency presents complications for both the clinician and the forensic psychiatrist. Patients with such coexisting disorders are often labeled dual-diagnosis or MICA patients. The psychiatric symptoms in a particular case may be related to one or the other diagnosis, or to the combined effects of both the cocaine use and the psychiatric disorder. Which disorder is considered "primary" with respect to symptoms and behavior is frequently debated. The label CAMI (chemically abusing/mentally ill) is sometimes used to distinguish those individuals who are diagnosed mentally ill, but whose substance dependence is primary.

Little is known about the specific psychotomimetic effects of cocaine intoxication in those with primary psychiatric disorders. A study of cocaine dependency among psychiatric in-patients in a metropolitan hospital [*10*] found that a large proportion of these patients were schizophrenic. A clear association between cocaine use and any unique psychotomimetic effect in this schizophrenic sample could not, however, be established. Schizophrenics who were dependent on cocaine were using smaller amounts compared with personality disorder patients, suggesting that they may have an increased vulnerability to developing cocaine addiction. Of particular interest to the forensic psychiatrist and legal scholar is that while hospitalized, by in large the schizophrenic group recognized that their use of cocaine was wrong, dangerous, and illegal. But like the other patients addicted to cocaine, they usually expressed overconfidence about their ability to control their subsequent use of cocaine. Schizophrenics also stated that they were more vulnerable to cocaine binging during periods when their thoughts were more disorganized.

Although cocaine dependence is a psychiatric disorder which is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R), the "voluntariness" associated with continued cocaine use is generally recognized as being more substantial than the persistence of symptoms of a major psychiatric disorder such as schizophrenia or major depression. Therefore, the personal and legal responsibility that one assumes for the consequences of the illness is generally considered greater for cocaine addiction than for schizophrenia or major depression. In criminal cases with MICA defendents, the contribution of the primary psychiatric disorder to the diminution or lack of criminal responsibility is therefore usually emphasized by the defense, and conversely the perception of cocaine use as an antisocial behavior is often emphasized by the prosecution. Heavy cocaine use is associated with the development of paranoid thinking as well as paranoid delusions. There is a disorder, categorized in DSM-III-R as cocaine delusional disorder, that is sometimes used as the basis of an insanity defense, but this diagnosis is generally regarded as a risky and weak insanity plea. However, the defense often argues successfully that the paranoid-generating effects of cocaine will acutely exacerbate an underlying paranoid or schizophrenic disorder.

A criminal act is most often related to the personality structure of an individual, regardless of whether a psychiatric disorder or cocaine dependency is present. Cocaine

users and addicts are a very heterogenous population; many cocaine addicts are truly good-natured and decent persons who have become unfortunate victims of a pathological affliction, and many others are sociopathic and depraved individuals who become addicted to cocaine. Meloy [*11*] considers cocaine and stimulants to be the favored drug of abuse among psychopathic or antisocial personalities. Many heavy cocaine users commit violent crimes regularly, yet many others never become involved in violent crimes. The underlying personality of an individual should be the most important factor in determining criminal responsibility, and it is a phenomenon that can be evaluated separately from addictive or psychotic behavior. This critical relationship is important to bear in mind, both to protect the individual using cocaine from becoming the victim of prejudice, as well as for the benefit of the society at large. Although cocaine use can and usually does change one's personality over time, the individual's underlying personality is usually modified rather than undergoing a sudden, radical change. The forensic psychiatrist in these cases should convey the importance of an unbiased assessment of the personality—that the use of cocaine does not imply that one's personality is antisocial, but that many antisocial personalities do use cocaine.

Drugs of abuse, including cocaine, may have a disinhibiting effect on behavior. This effect has long been associated with alcohol intoxication. Alcohol, a central nervous system depressant, decreases anxiety, and it is anxiety that inhibits many of our actions. Thus, under the influence of heavy alcohol intoxication, one is much more prone to reckless or aggressive behavior. Even though one's volitional control over such disinhibited behavior is unequivocally diminished, the legal doctrine that applies to this disinhibited behavior is the voluntary intoxication rule. That is, if the intoxication is voluntary, one is fully culpable for the disinhibited behavior associated with the intoxication. Cocaine's effect with respect to disinhibiting behavior is somewhat more ambiguous and controversial. Cocaine is a central nervous system stimulant. It does not diminish anxiety. However, many cocaine users report that it is behaviorally disinhibiting in a different way. Some cocaine addicts refer to cocaine with the street-slang term, "truth serum." Unlike the traditionally regarded truth serum amytal [also a central nervous system (CNS) depressant with disinhibiting effects similar to alcohol], cocaine's effect is to heighten one's natural or instinctive drive to act, and to even act impulsively, aggressively, or explosively under particular circumstances, without the normal regard for the consequences of such behavior. This disinhibiting effect can be likened to the "unmasking" of a person's underlying predilections.

From a forensic science perspective, these cocaine-induced disinhibited behaviors should be regarded as governable under the same legal doctrine of the voluntary intoxication rule that previously has been established. It is important for the forensic psychiatrist to clarify this matter to the court, regardless of "the side" he or she is testifying for. It is usually a concession for both the defense and prosecution. For example, if a defendant on an assault charge was using cocaine at the time of the offense, the use of cocaine would have an effect of increasing the likelihood of assaultive behavior with intent, as well as increasing the likelihood of psychotic behavior without malicious intent. Expert witnesses on both sides should concede these two distinct phenomenological effects of cocaine. The final determination regarding mens rea or intent should be based on the facts of the case as well as on the data from the psychiatric evaluation. The role of the jury or judge as the determiner of fact should be acknowledged by the expert witness.

A case example will be used to illustrate these points. The defendant in this case is a 36-year-old man charged with two counts of murder in the second degree, two counts of arson, and one count of reckless endangerment. He admits that he is addicted to cocaine. He stated that one night after he binged heavily with freebase cocaine, he became suicidal and disoriented. He said that subsequently he set fire to his room during a suicide attempt without realizing that his wife and child were present in the house. His wife and child

died of smoke inhalation. Without elaborating on the defendant's past psychiatric history, life history, or personality profile, the forensic issues in this case can be clarified. Cocaine binging can have the effect of producing suicidal or psychotic behavior, and it can also have the effect of aggravating aggressive impulses (its disinhibiting effect). The determination of the defendant's true intent or mens rea at the time of the act must take into consideration the fact pattern, the past psychiatric history, and the personality assessment. An expert witness in this case should acknowledge the two different types of effects of cocaine use, and then elaborate on which effect was most likely in the context of the totality of clinical data.

Conclusion

The expert witness who consults in cocaine-related criminal proceedings faces a formidable task indeed. Philosophically, there are two discordant poles to contend with. On the one hand, those who are addicted to cocaine and charged with a crime often face a very hostile stigmatization. On the other hand, there is a serious growing public concern about the need to control permissive attitudes about cocaine abuse and related crimes. The role of the forensic psychiatrist or psychologist in these cases is often a very controversial one. The skill of a well-trained expert witness encompasses both the ability to judiciously balance the issues in a legal sense, as well as to examine the facts objectively in a scientific sense.

A forensic psychiatrist has a duty to educate the public regarding the facts about psychiatric disorders. Cocaine addiction is a disorder that raises some of the most difficult questions about the nature of the mind, the brain, and the role of individual responsibility in determining one's behavior. Social attitudes toward drug abuse fluctuate from periods of intolerance to permissiveness before reaching a healthy middle ground. Both extremes are damaging to the individual as well as to society at large. The prudent expert witness in these proceedings should have an expressed, balanced appreciation of the dual concepts of enabling and restricting from an individual as well as from a social perspective.

This treatise outlines an approach that the forensic psychiatrist can follow for MICA cases. Perhaps its novel contribution is that from a forensic perspective the psychiatric effects of cocaine can be divided into the disinhibiting and the psychotomimetic. With regard to the disinhibiting effects, which include impulsivity, impaired judgment, and explosiveness, there is a legal standard that previously has been established for other drugs of abuse, that is, the voluntary intoxication rule, which should apply to cocaine-disinhibited behaviors. The psychotomimetic and suicidal effects of heavy cocaine use pose more complicated psychiatric-legal questions. It is important that the forensic psychiatrist concede that cocaine does have these two distinct types of untoward effects on an individual's behavior. This concession can be articulated in a way that is fair to both prosecution and defense; that is, the individual should neither be stigmatized nor exculpated for cocaine-related behavioral changes. Further elaboration on which effects were predominant in any individual case can then be articulated by the expert based upon the fact pattern and the data from the psychiatric evaluation. Recognition of the role of the judge or jury as the trier of fact should also be acknowledged. In this way, the forensic psychiatrist or psychologist provides accurate information as well as appearing more professional and unbiased in the expert testimony.

Given the magnitude of the cocaine-related crime problem, there will be an ever-increasing need for expert psychiatric testimony. In the years ahead, cocaine-related forensic science cases will continue to pose an exciting and necessary challenge for our profession.

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Erratum

In the article, "The Trial of Louis Riel: a Study in Canadian Psychiatry" (Vol. 37, No. 3, May 1992, p. 852), I erred in stating that Valentine Shortis was found not guilty of homicide, a verdict supported by the cabinet. In actuality, the insanity defense failed and Shortis was sentenced to death. The cabinet was evenly split over a recommendation for clemency. The Governor General, Lord Aberdeen, then commuted Shortis to "imprisonment for life as a *criminal lunatic* (italics mine), or otherwise as may be found fitting." This action exacerbated the discontent of French-Canadians over the Riel case. This decision in the Shortis case may have been a factor in the election of a Liberal, Wilfrid Laurier, who became the first French-Canadian prime minister of Canada in 1986.

Shortis remained incarcerated for 42 years; in the earlier years, he was frequently described as mentally ill. In his later years, he apparently functioned quite well and was released at age 62 in 1937; in 1941 he died suddenly of a heart attack.

Both the Jackson and Shortis cases reflect the fact that Canadian authorities were not adverse to considering the impact of mental illness in deciding the disposition of offenders, a step that was rejected in the Riel case.

I wish to thank Abraham L. Halpern, M.D., for bringing this error to my attention.

Irwin N. Perr, MD, JD

Erratum

The articles that appeared in the May issue of the journal under the Psychiatry and Behavioral Science Section Awards were erroneously labeled Case Reports on the title page.