ADDICTION, GENETICS, AND CRIMINAL RESPONSIBILITY

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It is clear that genes build proteins, but God only knows what happens next . . . . If you want to know how the mind works, you should investigate the mind; not the brain, and still less the genome. . . .[1]

I

INTRODUCTION

An immense proportion of alleged felons are under the influence of mind-altering substances when they are arrested, and many people arrested for drug offenses and other crimes are addicted.[2] Indeed, possession and use of illicit substances, which are necessary criteria of addiction,[3] are crimes in every state and under federal law. Assessing the moral and legal responsibility of agents who engage in such behavior is thus of paramount importance in our criminal

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This Article is also available at http://www.law.duke.edu/journals/lcp.

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This paper was first presented at a conference, "The Impact of Behavioral Genetics on the Criminal Law," at the Duke Law School. I thank Ed Greenlee for invaluable help. As always, my personal attorney, Jean Avnet Morse, provided sound, sober counsel and moral support.

1. Jerry Fodor, *Crossed Wires*, TIMES LITERARY SUPPLEMENT, May 16, 2003 at 3.

2. *See* ZHIWEI ZHANG, NAT'L OPINION RES. CENTER, DRUG AND ALCOHOL USE AND RELATED MATTERS AMONG ARRESTEES tbls. 3, 9 & 10 (2003) (showing that 73.9% of male adult arrestees in thirty-nine cities tested positive for alcohol or at least one of nine controlled substances, that 37% had engaged in the heavy use of controlled substances and 39.1% were at risk for drug dependence, and that 47.9% had engaged in heavy drinking within the past thirty days and 28.6% were at risk for alcohol dependence). I recognize that there is no consensual, scientifically or clinically operationalized definition of "addiction" and that the diagnostic and statistical manual of the American Psychiatric Association uses the terms "substance dependence" and "substance abuse" to refer to substance-related disorders. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000). Toward the extremes of drug use behavior, however, addiction could be characterized as Supreme Court Justice Potter Stewart characterized "hard core" pornography: Even if we can't define it, we know it when we see it. Jacobellis v. Ohio, 378 U.S. 184, 197 (1964). For ease of exposition, the term addiction will be used throughout the paper. Also for ease of exposition, addictions will be treated as limited to substance-related problems. Many believe that addictions encompass nonsubstance activities, such as gambling, and there is research evidence supporting this position. *See* Jon E. Grant et al, *Multicenter Investigation of the Opioid Antagonist Nalmefene in the Treatment of Pathological Gambling*, 163 AM. J. PSYCHIATRY 303 (2006) (finding that an opioid antagonist successfully reduces the symptoms associated with pathological gambling, suggesting that the disorder is not about gambling but about addiction in general). This position remains controversial, however, and arguing for it is unnecessary for the purposes of the present paper.

3. *See* Eric J. Nestler, *Genes and Addiction*, 26 NATURE GENETICS 277, 277 (2000) ("Drug addiction . . . is defined solely in behavioural terms. For example, addiction can be considered . . . compulsive drug-seeking and -taking despite horrendous consequences."). This definition is discussed further *infra*.

justice system. But understanding the moral and legal responsibility of people for becoming addicted and for criminal conduct associated with their addictions has unfortunately been hindered by inadequate understanding of how explanatory models of addiction relate to responsibility. Even sophisticated people tend to think that the "man with the golden arm" is somehow an automaton, a puppet pulled by the narcotic strings of a biological disease, and that therefore the addict is not responsible for actions associated with his addiction. Evidence linking a genetic predisposition for this condition contributes powerfully, often confusingly, to this type of thinking.[4] Conversely, many people think that addiction is purely a result of moral weakness. The various characterizations of addiction may be striking and contain a grain of truth, and many models have great heuristic power. For the law's purposes, however, the metaphors and models often obscure rather than clarify issues of criminal responsibility and of social policy generally in response to the deviant behavior many addicts exhibit.

This article has two simple underlying theses. The first is that it is impossible to understand the relation of any variable to criminal responsibility without having in place an account of criminal responsibility. The second is that discovery of genetic or of any other physical or psychosocial cause of action raises no new issues concerning responsibility, and discovery of such causes does not per se create an excusing or mitigating condition for criminal conduct or any other type of behavior.

This article begins in Part II with a brief description of the phenomenology of addiction, describing generally what is known about the behavioral aspects of addiction in addition to the basic criteria of craving, seeking, and using. Thinking sensibly about the relation of addiction to criminal responsibility is impossible unless it is first understood that this condition is "defined solely in behavioural terms."[5] Part III addresses the contrast between the legal and scientific images of behavior, using the disease concept of addiction, now fueled by discoveries of genetic predisposition, as a prime example of the contrast.

Part IV offers a general model of criminal responsibility to guide the analysis of responsibility for addiction-related criminal behavior, offering the best positive account of the present system. The model's essential criteria are behavioral, broadly understood to refer to actions and mental states. Part V deals with persistent confusions about responsibility. Part VI describes those aspects of addiction, if any, for which persons might be held morally or legally responsible, concluding that only actions related to addiction are appropriate objects for ascribing criminal responsibility. Part VII addresses the causal role genetics plays in explaining addiction. This discussion is deferred until this

4. *See generally* Johannes Keller, *In Genes We Trust: The Biological Component of Psychological Essentialism and Its Relationship to Mechanisms of Motivated Social Cognition*, 88 J. PERSONALITY & SOC. PSYCHOL. 686 (2005) (validating a scale to measure the belief in genetic determinism and demonstrating that such a belief affects social cognition).

5. Nestler, *supra* note 3, at 277.

point because, as earlier parts explain, no particular causal explanation of any behavior, including a biological explanation, entails necessary legal consequences. In particular, the existence of a genetic explanation for addiction does not demonstrate that addicts are not acting when they seek and use substances or engage in other activities related to their addiction and a genetic explanation produces no necessary legal conclusion concerning responsibility for such addiction-related actions.

Finally, Part VIII considers individual and social responsibility for the addiction-related actions. It begins by discussing in detail the meaning of those features of addiction—subjective craving and compulsion—that seem the most likely predicates for excuse or mitigation. It argues that understanding the biological roots of craving does not yet yield valid information concerning the strength of craving and seemingly compulsive behavior. This part next addresses the two leading theoretical and legal candidates for an excusing condition—internal coercion and lack of the capacity for rationality. It concludes that most addicts should be responsible for most criminal behavior motivated by addiction, but that addiction can in some cases affect the agent's ability "to grasp and be guided by reason."[6] The last section of this part considers whether society is responsible for addiction-related actions. It concludes that even if most addicts should be held responsible for addiction-related behavior, sensible social policy can do much to reduce both the prevalence of addiction and concomitant criminal behavior. The final part of the paper discusses three legal proposals for reducing the costs associated with addictions and for treating addicts fairly.

The paper throughout makes the simplifying assumption that addicts are *not* responsible for becoming addicted. If the addict is responsible for becoming addicted, then it is less problematic to hold the addict responsible for the foreseeable and unforeseeable consequences of becoming addicted.[7] As everyone concedes, becoming addicted virtually always involves intentional action. The addict must have intentionally used the substance, usually for prolonged periods. If the addict is responsible for substance use, then, arguably, she is also responsible for setting in motion those mechanistic, biophysical processes that partially cause addiction and that are activated or potentiated by using substances. The relation of genetic or other biological causation to responsibility then becomes much less important and interesting. Consequently, to raise the issues most starkly and most sympathetically to the

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6. This felicitous phrase is borrowed from Jay Wallace's superb book on responsibility. R. JAY WALLACE, RESPONSIBILITY AND THE MORAL SENTIMENTS (1994). Wallace treats the phrase as encompassing both rationality and control defects. I prefer to limit it to the former, however, and will suggest that most control defects can be assimilated to rationality defects.

7. *See, e.g.*, Montana v. Egelhoff, 518 U.S. 37 (1996) (upholding the constitutionality of a state statute excluding evidence of intoxication relevant to whether the defendant in fact had the subjective mens rea required by the definition of the crime). I firmly reject such partial or complete strict liability, but it is a common feature of the criminal law. *See* Stephen J. Morse, *Fear of Danger, Flight from Culpability*, 4 PSYCHOL. PUB. POL'Y & L. 250, 254 (1998).

view that biological causation may play an excusing role, it is assumed that addicts are not responsible for becoming addicted. This assumption is relaxed primarily in Part VIII.B, which discusses whether addicts should be excused because addiction compromises their rational capacities. A postscript considers in detail whether addicts are responsible for becoming addicted.

II

THE PHENOMENOLOGY OF ADDICTION

Here, in common-sense terms, is what we know about the phenomenology of addiction.[8] A later section considers in detail attempts to define more precisely some of the key terms, such as "craving" and "compulsive."

Some people use substances for which they develop an extremely intense, insistent level of subjective desire that is apparently satisfied only temporarily by use. After the addict satisfies the craving by use, the desire to use substances quickly reasserts itself and the agent again desires to use very intensely. Addicts typically engage in repetitive seeking and using behavior, even though the drug-related actions threaten and often cause adverse, frequent, and horrendous social, health, and legal consequences. Addicts have very good long-term reasons not to engage in drug seeking and use, but they tend to be steep time discounters when they evaluate drug seeking and using. For some, use may be rational in the short-term. Addicts do not seem to learn from experience, however. Thus, many continue to use and to imperil their lives. Most are ambivalent about their addictions. For some, the craving is so strong that seeking and using the substance becomes a central life activity and even central to the addict's identity. Many, and perhaps most, who quit will relapse, especially if the "drug life" has compromised functional social networks and skills.

It can be inferred from the addict's report about his or her own thoughts and feelings and from the negative consequences of addiction-related actions that the addict is driven by an overwhelming or overpowering desire termed "craving" and that drug seeking and using are "compulsive." But the environment and expectations play a weighty role in the addict's experience of craving and use. Addiction is a condition that is eliminated by large numbers of craving sufferers simply by intentionally ceasing to seek and use, and many cease craving after they quit. In many cases, the addict is able to quit because she finally has sufficient reason to do so, and many addicts "age out" of addiction. Even if addiction is properly and most usefully characterized as a disease, at the extreme its necessary behavioral signs are virtually all reward-sensitive or reason-responsive. An addict threatened with instant death for

8. What follows in this part is boilerplate among addiction researchers. Support can be found in the many scientific studies of addiction cited in this article and in many first-person accounts of addiction. Part VIII.A., *infra*, addresses attempts by scientists to define craving and compulsion more precisely.

seeking and using will not seek and use unless she already wishes to die at that moment or does not care if she does.[9]

III

IMAGES OF ADDICTION

The concepts of illness and disease have powerful associations in our culture, most of which are inconsistent with the sufferer's responsibility for the features of the illness. People can, of course, be responsible for initially contracting or risking contracting diseases. A person who is overweight, does not exercise, and smokes surely is responsible for risking hypertension; the person who in inappropriate circumstances engages in unprotected sexual activity surely risks contracting sexually transmitted diseases. And a person who suffers from many diseases can ameliorate the consequences by intentionally adhering to a prescribed medical regimen. But hypertension and infections are themselves mechanisms. The sufferer cannot terminate all the signs and symptoms of the disease simply by intentionally choosing to cease being hypertensive or infected.

Despite the potential contribution of human agency to the cause and maintenance of some diseases, no one denies that these are fundamentally diseases. Moreover, with many and perhaps most diseases, the sufferer is not responsible for contracting the disease, and for many diseases there is little or nothing the sufferer can do to help, other than to seek and cooperate with professional help and to wait for the disease to run its course. Although people sometimes can be complicit in their own diseases, the disease model is so powerful that people who are ill are not in general considered responsible for the signs, symptoms, and consequences. The dominant image of people with diseases is that they are the victims of pathological mechanisms who deserve sympathy and help and do not deserve condemnation.

The brain disease model of addiction borrows heavily from the powerful moral and social associations of the general concepts of illness and disease. It claims that addiction is a chronic and relapsing brain disease.[10] Supported by highly technical anatomical, physiological, and genetic research demonstrating that addictions appear to have a biological basis, the brain disease model inevitably suggests that the addict is sick. The signs and symptoms of the disease—primarily compulsive drug seeking and use—are seemingly the mechanistic consequence of genetically-driven pathological brain anatomy and physiology over which the addict has no control once prolonged use has caused the pathology. The following are recent excellent examples of this mode of

9. The ability of many addicts to decide to quit and to be responsive to contingencies generally is an inconvenient fact for those who wish to conceptualize addiction as purely a brain disease. People do not stop being diabetics, for example, simply by deciding that their pancreases should produce more natural insulin nor does cancer abate because people have good reason to be free of this terrible disease. *See infra* Parts III & VI.

10. Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 1 FOCUS 190 (2003).

thought that appeared in prestigious journals. The first is by an eminent neuroscientist:

> Dramatic advances over the past two decades in both the neurosciences and the behavioral sciences have revolutionized our understanding of drug abuse and addiction. Scientists have identified neural circuits that subsume the actions of every known drug of abuse, and they have specified common pathways that are affected by almost all such drugs. Researchers have also identified and cloned the major receptors for virtually every abusable drug, as well as the natural ligands for most of those receptors. In addition, they have elaborated many of the biochemical cascades within the cell that follow receptor activation by drugs. Research has also begun to reveal major differences between the brains of addicted and nonaddicted individuals and to indicate some common elements of addiction, regardless of the substance.[11]

The second is by an addiction researcher:

> Addiction is a disorder of the brain's reward system. Functional imaging shows the vulnerable circuitry for addiction originating in the paleocortex. Paradoxically, humankind's greatest adaptive advantage, the neocortex, responsible for the phenomenon of consciousness, is at best only minimally protective from addictive disease and may pose a hurdle for recovery. Unlike most medical disorders, in addiction a net effect of supraphysiologic reward, impaired inhibition, or both paradoxically leads the limbic drive system to reinforce exposure to the disease vector. This is in direct violation of the principle of survival of the species. In individuals with underlying vulnerabilities, limbic drive progressively recruits neocortical function to protect continued access to abused substances, the polar opposite of self-preservation.[12]

The first example, despite the concession to the behavioral sciences in its first sentence, describes solely biological advances, and the remainder of the article fails to note one "dramatic advance" in the behavioral understanding of addiction.[13] The second example treats the intentional conduct of the addict solely as the product of brain mechanisms. There is no person present, no agent acting when the "organism" seeks and uses.

For those whose thinking is driven by the brain disease model, this image is applauded and promoted. For example, an editorial in the *American Journal of Psychiatry* opens as follows:

> American psychiatry has made remarkable progress in recategorizing the addictive disorders from moral failures to brain diseases, but the need for community education continues. The concept of moral failure is by no means gone from the discussion of addictive disorders, as evidenced by our country's investment in criminal justice rather than treatment . . . .[14]

Such thinking can reflect in part battles over turf, funding, and the like, but it is doubtlessly sincerely motivated.

Virtually all mechanistic models of problems that bedevil society, including the medical model, are alluring because they imply that there are technical,

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11. Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 278 SCIENCE 45, 45 (1997).

12. David R. Gastfriend, *Physician Substance Abuse and Recovery: What Does it Mean for Physicians—and Everyone Else*, 293 JAMA 1513, 1514 (2005) (citation omitted).

13. Leshner, *supra* note 11.

14. Thomas R. Kosten, *Addiction as a Brain Disease*, 155 AM. J. PSYCHIATRY 711, 711 (1998); *accord* Alan I. Leshner, *Science is Revolutionizing Our View of Addiction—and What to Do About It*, 156 AM. J. PSYCHIATRY 1 (1999).

"clean" solutions. Fix the "pathological mechanism," fix the social problem it produces; do not worry about refractory human behavior and messy moral accountability. The medical model is used here for rhetorical purposes because it is much in the news, and because there is heartening progress in the biological understanding of addiction. But any black-box mechanical model of the phenomenon of addiction would have done as well.

Criminal law's concept of the person, including the addict, is the antithesis of the medical model's mechanistic concept. Although all honest people will admit that biological and environmental variables beyond the person's rational control can cause an agent to be the type of person who is predisposed to commit crimes or can put the agent in the kind of environment that predisposes people to criminal activity, the law ultimately views the criminal wrongdoer as an agent and not simply as a passive victim who manifests pathological mechanisms.[15] Unless either the person does not act or an excusing condition is present, agency entails moral and legal responsibility that warrants blame and punishment. Suffering from a disease *simpliciter,* such as schizophrenia, does not itself mean that the defendant did not act or that an excusing condition obtained, although diseases and other causes may negate action or produce an excusing condition, such as gross irrationality. Most mental and physical diseases—even severe disorders—suffered by people who violate the criminal law do not have these exculpating effects because they do not sufficiently affect rational agency concerning criminal activity.[16] Even if addiction is properly characterized as an illness, most addicts are nonetheless capable of being guided by good reasons, including the incentives law can provide.[17] Sick people who behave immorally or who violate the criminal law are almost always responsible agents.

Why does it matter if we conceptualize drug-related problems medically as the product of genetic predisposition and a brain disease? After all, drugs undoubtedly cause vast and often catastrophic personal and social misery, and perhaps the program of research and intervention the biological disease model implies can ameliorate the misery. Why should internecine disputes among philosophers of biology and medicine about the status of the disease concept, or

15. In Powell v. Texas, 392 U.S. 514 (1968), a case involving a chronic alcoholic convicted of being drunk in public, the Supreme Court held that a defense of "compulsion symptomatic of a disease" was not constitutionally required. The Court wrote that public drunkenness was behavior, and thus unlike the simple status of being addicted, and it refused to hold that criminal blame and punishment were constitutionally impermissible under the circumstances. Indeed, Justice Marshall's plurality opinion observed that it was not irrational to respond to public drunkenness with the criminal sanction. *Id.* at 527–31. The plurality also pointed out that Powell's own cross-examination at trial suggested that he was not powerless to stop drinking after he had taken his first drink. *Id.* at 519–21.

16. Mental disorders, even severe mental disorders, seldom negate the act requirement for criminal culpability and equally rarely negate either the mens rea required by the definition of crimes or the intentionality of unlawful conduct. *See* Stephen J. Morse, *Crazy Reasons*, 10 J. CONTEMP. LEGAL ISSUES 189, 210 (1999) (considering the act requirement); Stephen J. Morse, *Craziness and Criminal Responsibility*, 17 BEHAV. SCI. & L., 147, 161–64 (1999) (concerning mens rea).

17. *See* SALLY L. SATEL & FREDERICK K. GOODWIN, ETHICS & PUB. POLICY CTR., IS DRUG ADDICTION A BRAIN DISEASE? 20–21 (1998).

the law's model of the person, or the pure moralizing of many stand in the way? They should not, of course; nothing should stand in the way of useful research and interventions. Unfortunately, however, otherwise useful images or models can have negative consequences if they exceed their rightful boundaries. The wrong images in an inapt domain can produce misguided policies.

Whether the law should treat addiction as a disease and what that would mean are open conceptual and practical questions. Let us begin by examining the law's model of responsibility ascription.

IV

THE MODEL OF CRIMINAL RESPONSIBILITY

The criteria for criminal responsibility, like the criteria for addiction, are entirely behavioral. An agent is criminally responsible if his or her intentional action, accompanied by an appropriate mental state, satisfies the definition of a criminal offense. If the agent does not act at all because her bodily movement is not intentional—for example, a reflex or spasmodic movement—then there is no violation of the prohibition. There is also no violation in cases in which the agent's intentional action satisfies the offense's act definition, but the mental state required by the definition is lacking. In Anglo-American criminal law, an agent unjustifiably violating a criminal prohibition will be held not responsible and legally excused if she was incapable of rationality or was metaphorically compelled to act by being placed in a "do-it-or-else," hard-choice situation.[18] Note that in cases of metaphorical compulsion, unlike cases of no action, the agent does act intentionally. Infancy and legal insanity are doctrinal examples of rationality excuses; duress is an example of a hard-choice excuse. The criteria for the excusing conditions—lack of rational capacity and sufficiently hard choice (compulsion)—are normative. The degree of rational capacity required for responsibility and how hard choices must be to excuse can differ in response to changing moral conceptions and material circumstances.

This account of criminal responsibility is most tightly linked to retributive justifications of punishment, which hold that punishment is not justified unless the offender morally deserves punishment because the offender was at fault and responsible, and that the offender never should be punished more than she deserves. It is generally conceded that desert is at least a necessary precondition for punishment in Anglo-American law.[19] The account is also consistent with consequential justifications for punishment, such as general deterrence. No offender, including an addict, should be punished unless he or

18. A justification exists if action that would otherwise be criminal is right or permissible under the circumstances. Self-defense is an example. An excuse exists if the agents acts wrongfully, but the agent is not responsible for his or her conduct. Legal insanity is an example. *See* Kent Greenawalt, *The Perplexing Borders of Justification and Excuse*, 84 COLUM. L. REV. 1897 (1984) (distinguishing justification and excuse and examining the often hazy boundaries between them).

19. Exceptions, such as strict liability, are few and highly controversial precisely because they permit punishment in the absence of fault.

she at least deserves such punishment. Even if good consequences might be achieved by punishing non-responsible addicts or by punishing responsible addicts more than they deserve, such punishment would require very weighty justification in a system that takes desert seriously.

This brief description is arguably the most accurate positive account of the current, dominant Anglo-American conception of responsibility. One might quibble about details,[20] but the basic thesis—that responsibility is based on ordinary, common-sense behavioral criteria such as action, mental states, and rationality, and that responsibility is tied to desert—is accurate. Now, many people become confused about these criteria when they consider newly discovered scientific evidence concerning the causation of behavior or if they have more fundamental metaphysical doubts about the legitimacy of criminal responsibility and consequent deserved punishment. As the next part argues, such concerns are dangerous distractions that either confuse analysis or prove too much by threatening all conceptions of responsibility.

V

DANGEROUS DISTRACTIONS CONCERNING RESPONSIBILITY

A persistent but confused (and confusing) thought is that discovery of genetic or other biological causes implicates the free will versus determinism debate, and, relatedly, that causation is per se an excusing condition.[21] That determinism threatens responsibility is a truism. Although no one can know if determinism or something close to it is true, let us assume that it is. After all, the universe is massively regular above the sub-atomic level, and it would be strange indeed if the phenomena of the universe were mostly or entirely random or indeterministic.[22]

The alleged incompatibility of determinism and responsibility is foundational. Determinism is not a continuum concept that applies to various individuals in various degrees. There is no partial or selective determinism. Responsibility is possible or it is not, *tout court*, if the universe is deterministic. If human beings are fully subject to the causal laws of the universe, as a thoroughly physicalist, naturalist worldview holds, then many philosophers

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20. For example, there is a debate about whether justified conduct violates a moral or criminal prohibition. Some argue that justifiable conduct violates no prima facie obligation. *See* MICHAEL MOORE, PLACING BLAME: A GENERAL THEORY OF THE CRIMINAL LAW 31–33, 64–67 (1997) (arguing that justification should be treated as part of the "special part" of the criminal law). A more formalistic criminal law analysis holds that justified conduct does violate a prima facie criminal prohibition, but ultimately the conduct is judged right or at least permissible. In either case, illicit drug activity is almost never justified under current legal doctrine.

21. *See, e.g.*, Comm. on Addictions of the Group for the Advancement of Psychiatry, *Responsibility and Choice in Addiction*, 53 PSYCHIATRIC SERVICES 707, 708 (2002) (pointing to genetic and biological factors responsible for addiction and suggesting that partial determinism or causation provides a partial excuse).

22. Galen Strawson calls this assumption the "realism constraint." Galen Strawson, *Consciousness, Free Will, and the Unimportance of Determinism*, 32 INQUIRY 3, 12 (1989). If the universe were indeterministic or random, it would hardly provide a secure foundation for responsibility.

claim that "ultimate" responsibility is impossible from the start.[23] On the other hand, plausible "compatibilist" theories suggest that responsibility is possible in a deterministic universe.[24] There seems no resolution to this debate in sight, but our moral and legal practices do not treat everyone or no one as responsible. Determinism cannot be guiding our practices. If one wants to excuse addicts because they are genetically determined or determined for any other reason to be addicts, one is committed to negating the possibility of responsibility for anything.

Our criminal responsibility criteria and practices have nothing to do with determinism or with the necessity of having so-called "free will." Criminal responsibility involves evaluation of intentional, conscious, and potentially rational human action. And almost no one in the debate about determinism and free will or responsibility argues that we are not conscious, intentional, potentially rational creatures when we act. We may be deterministically caused to be the type of creature that acts intentionally, but determinism is not inconsistent conceptually or logically with the possibility of mind-brain causation of behavior. The truth of determinism does not entail that actions and non-actions are indistinguishable and that there is no distinction between rational and non-rational actions or compelled and uncompelled actions. Children are less rational than adults; most people most of the time do not act under severe threats. Our current responsibility concepts and practices use criteria consistent with and independent of determinism.

A related confusion is that once a non-intentional causal explanation has been identified for action, the person must be excused. In other words, the claim is that causation and responsibility are inconsistent and that causation per se is an excusing condition. This is sometimes called the "causal theory of excuse." Thus, if one identifies genetic, neurophysiological, or other causes for behavior, then allegedly the person is not responsible. In a thoroughly physical world, however, this claim is either identical to the incompatibilist critique of responsibility and furnishes a foundational critique of all responsibility, or it is simply an error. I term this the "fundamental psycholegal error" because it is erroneous and, indeed, incoherent as a description of our practices.[25] Non-causation of behavior is not and could not be a criterion for responsibility because all behaviors, like all other phenomena, are caused. Causation, even by abnormal physical variables, is not per se an excusing condition. Abnormal physical variables, such as neurotransmitter deficiencies, may cause a genuine excusing condition, such as the lack of rational capacity, but then the lack of

23. *See, e.g.*, DERK PEREBOOM, LIVING WITHOUT FREE WILL (2001).

24. *See* WALLACE, *supra* note 6; Stephen J. Morse, *Reason, Results, and Criminal Responsibility*, 2004 U. ILL. L. REV. 363, 437–44 (2004).

25. Stephen J. Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587 (1994). Critics complain that this argument is repeated in many of my writings. I plead guilty to the charge and will continue to recidivate as long as people continue to manifest the confusion, as they routinely do. See Comm. on Addictions, *supra* note 21, and Anders Kaye, *Resurrecting the Causal Theory of the Excuses*, 83 NEB. L. REV. 1116 (2005), for recent examples.

rational capacity, not causation, is doing the excusing work. If causation were an excuse, no one would be responsible for any action. Unless proponents of the causal theory of excuse can furnish a convincing reason why causation per se excuses, we have no reason to jettison responsibility practices that use other criteria for responsibility and excuse.

In short, the burden of persuasion is on critics of the positive account of responsibility that has been offered to guide our thinking about responsibility and addiction. They must show either that it is an inaccurate account or that our entire system of blame and punishment is normatively indefensible. Until they accomplish this, they must work within the model. There can be disagreement about how much lack of rational capacity excuses or how hard choices must be to excuse, but determinism and causation are simply dangerous distractions.

VI

ASPECTS OF ADDICTION; OBJECTS OF RESPONSIBILITY

Roughly speaking, addiction has four associated aspects or phenomena that might be objects of responsibility ascription: anatomical states, physiological states, psychological states, and actions.[26] Among these, only action is a potentially appropriate object of moral and legal responsibility ascription and a justification for criminal punishment.[27] For the most part, people are held morally and legally responsible only for actions that are capable of being guided by reason. Although anatomical and physiological states, including one's genetic make-up, may be evaluated as desirable or undesirable, they are entirely or largely the product of mechanistic processes that are not under the agent's rational control. Those anatomical and physiological states that are signs of addiction are simply statuses of the agent's physical body and not directly controllable through the person's rational agency. Similarly, a psychological state that is symptomatic of addiction, such as craving (or, according to many, ambivalence), is likewise just a status that is mechanistically produced by the underlying anatomical or physiological states associated with addiction and, in many cases, by environmental cues. Anatomical, physiological, and psychological states are not intentional human actions.[28] People may be responsible for the anatomical, physiological, and psychological states associated with addiction if they are responsible for becoming addicted,

26. *See* HERBERT FINGARETTE & ANN FINGARETTE HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 148 (1979).

27. *E.g.*, Robinson v. California, 370 U.S. 660 (1962) (holding that criminal punishment solely for the status of being addicted is cruel and unusual and thus constitutionally impermissible under the Eighth and Fourteenth Amendments).

28. Intentional mental acts do exist, of course. For example, intentionally adding two and two to find the sum is an intentional act. But a subjective feeling of craving or compulsion is not per se a mental act.

but the criminal law still would not punish those states because they are solely statuses.

The primary behavioral signs of addiction—seeking and using substances[29]—are intentional human actions, even if they are also signs of a disease that has genetic, anatomical, and physiological causes. Indeed, all intentional action has genetic, anatomical, and physiological causes, whether or not the action is the sign of a disease.[30] The addict has an exceptionally powerful desire—a craving—to consume the addictive substance, believes that consuming it will satisfy that craving by avoiding pain, causing pleasure, or some combination of the two, and therefore forms and acts on the intention to seek and to use the substance. Such explanatory practical syllogisms are the mark of all intentional actions.

Intentional action is the primary object of responsibility ascriptions. Seeking and using and other associated actions may therefore be morally and legally assessed. To assume that the addict is not responsible for addiction-related behavior just because it has biological causes or because the action is the sign of a disease generally commits the fundamental psycholegal error and therefore begs the question of responsibility. It is natural to think people are not responsible for signs and symptoms because mostly they are statuses mechanistically caused. But human action is distinguishable. It is not simply a status.

Before finally turning to the question of the responsibility of addicts, the role that genetics plays in causing the actions associated with addiction first must be understood. The next part undertakes that task.

VII

THE GENETIC ROLE IN THE CAUSATION OF ADDICTION-RELATED ACTIONS

Although environmental variables play an undeniably important role and sometimes explain a majority of the variance in the addict's behavior, the variance in agents' initial responses to a substance and the development of craving appear to have a genetic biological substrate. Virtually all addiction experts agree that addiction is a complex, heterogeneous phenotype, that many genes contribute only small effects, that the expression of those genes may be strongly influenced by the environment, that the heritability of most addictions probably does not exceed fifty percent,[31] and that the causal mechanisms are not

29. Jordi Cami & Magi Farré, *Mechanisms of Disease: Drug Addiction*, 349 N. ENG. J. MED. 975 (2003); Leshner, *supra* note 11, at 46 (defining the "essence" of addiction as, "compulsive drug seeking and use, even in the face of negative health and social consequences"); Nestler, *supra* note 3.

30. To claim otherwise is to deny the fundamental insight of biological physical naturalism that Darwin so profoundly explained.

31. *Heritability* refers to the proportion of the variance of a trait, such as height, cognitive ability, or the predisposition to find opiate use pleasurable, that can be attributed to genetic differences within some specifically defined population under some specific set of conditions. It does not refer to how much any individual person's expression of that trait is explained by genetic causes. Estimates of heritability in one defined population, say, males in a specific place, are not transferable to another

yet well understood.[32] Indeed, it is difficult to disentangle preexisting neural vulnerabilities from the effects of chronic use.[33] Despite the limitations in our present understanding, experts believe that there is no single gene or interacting set of genes that inevitably or even directly produce intentional seeking and using of drugs.[34] In general, complex behavioral traits, including those that are the expressions of a disease, are rarely explained by a single gene.[35]

Addiction may be a disease with a genetic basis, but it is not like Huntington's disease or other single-gene diseases that involve the inevitable and purely mechanistic expression of that gene. The genetic contributions to addiction instead affect "intervening" variables that can predispose the person to become addicted. For example, genetic factors may influence the agent's initial response to the substance; brain adaptations, including reward circuitry and the degree to which the substance is rewarding; disinhibitory mechanisms; physical dependence; and other variables that affect whether an agent who uses substances, especially for a prolonged period, compulsively seeks and uses because she is motivated by intense craving.[36] In short, and colloquially, the typically shorter-term "go" mechanisms of the brain are strengthened and the

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defined population, say, females in another place. Also, heritability must be distinguished from *heritable*. The latter refers to whether the expression of a trait is under some control by genes. In a genetically homogeneous population, a trait might be heritable but have a heritability of zero because genes do not explain variation in that population. In a population in which a trait is genetically homogeneous, all variance in that trait in the population would be explained by nongenetic variables. TIMOTHY H. GOLDSMITH & WILLIAM F. ZIMMERMAN, BIOLOGY, EVOLUTION AND HUMAN NATURE 92 (2001).

32. *E.g.*, ROBERT PLOMIN, JOHN C. DEFRIES, GERALD E. MCCLEARN, & PETER MCGUFFIN, BEHAV. GENETICS 265–72 (4th ed. 2001); John C. Crabbe, *Genetic Contributions to Addiction*, 53 ANN. REV. PSYCHOL. 435, 437, 451–52 (2002); Mary Jeanne Kreek, David A. Nielson & K. Steven LaForge, *Genes Associated with Addiction: Alcohol, Opiate, and Cocaine Addiction*, 5 NEUROMOLECULAR MED. 85, 86 (2004); Nestler, *supra* note 3. Alcoholism is the most intensely studied addiction. Future research will surely confirm a genetic contribution to addiction and provide increased understanding of the causal mechanisms. *See generally* Anne M. Glazier, Joseph H. Nadeau & Timothy J. Altman, *Finding Genes that Underlie Complex Traits*, 298 SCIENCE 2345, 2345–46 (2002)(proposing standards for proof of discovery of genes for complex traits); Kenneth S. Kendler, *Psychiatric Genetics: A Methodological Critique*, 162 AM. J. PSYCHIATRY 3 (2005) (reviewing the four major research paradigms and proposing that they be better integrated with recognition of the strengths and weaknesses of each).

33. Monique Ernst, Alane S. Kimes & Sandra Jazbec, *Neuroimaging and Mechanisms of Drug Abuse: Interface of Molecular Imaging and Molecular Genetics,* 13 NEUROIMAGING CLINICS N. AM. 833, 839 (2003); *see also* Véronique Deroche-Gamonet, David Belin & Pier Vicenzo Piazza, *Evidence for Addiction-like Behavior in the Rat*, 305 SCIENCE 1014, 1016–17 (2004) (stating the interaction of phenotypical vulnerability and length of exposure explains the onset of addiction).

34. William M. Compton, Yonette F. Thomas, Kevin P. Conway & James D. Colliver, *Developments in the Epidemiology of Drug Use and Drug Use Disorders*, 162 AM. J. PSYCHIATRY 1494, 1498 (2005) (stating drug use disorders are "genetically and phenotypically complex" and arise from "multiple genes exerting small effects," and *inter alia*, "gene-by-environment" interactions).

35. Crabbe, *supra* note 32, at 437; EVA JABLONKA & MARION J. LAMB, EVOLUTION IN FOUR DIMENSIONS: GENETIC, EPIGENETIC, BEHAVIORAL, AND SYMBOLIC VARIATION IN THE HISTORY OF LIFE 6 (2005); *see generally* Terrie E. Moffitt, Avshalom Caspi & Michael Rutter, *Strategy for Investigating Interactions Between Measured Genes and Measured Environment*, 62 ARCHIVES GEN. PSYCHIATRY 473, 474–78 (2005) (describing strategies to test hypotheses about gene-environment interactions).

36. *E.g.*, Nestler, *supra* note 3, at 278.

typically longer-term "stop" mechanisms are weakened.[37] None of these explanatory variables denies or is inconsistent, however, with the truth that seeking and using drugs and other drug-related behaviors are intentional actions.

It is of course possible that in many cases these addiction-predisposing genetic variables might be affected by environmental causes and that genetics might play only a trivial role. It would make no difference to the analysis of responsibility, however, that the causes of the predisposition were environmental rather than biological. Both the brain and the mind can be changed by both biological and psychological variables, and environmental causes may be every bit as powerful as biological causes. From the purely causal perspective, a cause is just a cause.[38] For the purpose of analysis, however, let us make the simplifying assumption that genetic causes over which the agent has no rational control always play a non-trivial role in causing the anatomical, physiological, and psychological changes associated with prolonged substance use and consequent addiction.

VIII

RESPONSIBILITY AND ADDICTION

An agent will not be held responsible for anatomical, physiological, or psychological states associated with addiction, but the addict potentially may be held responsible for addiction-associated actions such as possession, use, or other crimes motivated by the desire to obtain and use drugs. Thus, the addict must be evaluated as an acting agent, a person who acts for reasons, and not simply as a biophysical mechanism. This would be true even if craving and compulsive seeking and using drugs were the inevitable, mechanistic outcome of a single-gene defect. The question, then, is how to assess the responsibility of an agent acting intentionally and unlawfully, but apparently compulsively in response to cravings.

The criminal actions of addicts are in fact actions, not mechanisms, even if they may also be properly characterized as signs of disease or brain pathology, and discovery of biological or psychosocial causes does not per se negate agency and create an excusing condition. All actions have biological and non-biological causes. The agent is not an addict unless the person seeks and uses the drug. And when she seeks and uses, she acts. She is not legally unconscious, even according to the most extravagantly narrow definition of action, and she surely acts intentionally. Genetically induced pathology may be

37. *See generally* Samuel M. McClure et al., *Separate Neural Systems Value Immediate and Delayed Monetary Rewards*, 306 SCIENCE 503, 505–06 (2004) (finding that different areas of the brain are activated by short-term and long-term rewards; these findings are consistent with the view that our "passions" particularly affect short-term reward choices).

38. *See* JANET RADCLIFFE RICHARDS, HUMAN NATURE AFTER DARWIN: A PHILOSOPHICAL INTRODUCTION (2000) (providing a complete analysis of the indistinguishability of biological and social causation as threats to personhood and ordinary responsibility).

a prime source of a craving, and compulsive action to satisfy the craving may produce harmful consequences, but activity to satisfy the craving for drugs is nonetheless action. The core definition of addiction entails this.

The question, therefore, is whether addicts should be excused for their addiction-related actions. This part begins an answer with consideration of those features of addiction-related behavior—craving and compulsion—that are most relevant to an assessment of the criminal law's excusing conditions of lack of rationality and legal compulsion. It continues by addressing the two primary theoretical candidates for why actions motivated by cravings and compulsions might be excused—the internal compulsion and irrationality theories. Finally, it turns to society's responsibility for addiction-related behaviors and whether such responsibility negates or lessens individual responsibility.

A. The Meaning of Craving and Compulsion

This article previously explored the phenomenology of addiction and has implicitly accepted a common-sense understanding of craving and compulsion. Now let us consider whether more precise clinical and scientific definitions of craving and compulsion can be provided.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revision* (DSM-IV-TR)[39] does not use the term "addiction" and does not make craving and compulsive seeking or using *necessary* criteria of a substance disorder. Nonetheless, this article will consider what this manual and other authoritative sources teach about these crucial features of addiction.

DSM-IV-TR defines the generic "essential feature" of the class of substance dependence disorders as, "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior."[40] DSM-IV-TR does state, however, that "[a]lthough not specifically listed as a criterion item, 'craving' (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence."[41]

The *International Classification of Disorders* (ICD-10)[42] describes the dependence syndrome generically as follows:

> A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic

39. AM. PSYCHIATRIC ASS'N, *supra* note 2.

40. *Id.* at 192.

41. *Id.*

42. WORLD HEALTH ORGANIZATION, THE ICD-10 CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS (1992).

> of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs . . ., alcohol or tobacco.[43]

Two specific but *not* necessary ICD-10 criteria for dependence are a "strong desire or sense of compulsion to take the substance" and "difficulties in controlling substance-taking behaviour."[44]

With respect, these definitions of craving and related states are conclusory, vague, and unoperationalized. This problem is not remedied by consulting other analogous criteria or definitions. For example, DSM-IV-TR defines the "essential feature" of an Impulse-Control Disorder as, "the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others."[45] In its generic introduction to impulse-control disorders, the manual continues: "For most of the disorders in this section, the individual feels an increasing sense of tension or arousal before committing the act and then experiences pleasure, gratification, or relief at the time of committing the act."[46] Again, this definition may be related in a loose way to what one might mean by craving or compulsion, but it is surely over inclusive as a precise definition of these terms.

Finally, DSM-IV-TR's formal use of the diagnostic term, "compulsion," which is defined as part of Obsessive-Compulsive Disorder, an anxiety disorder, bears little relation to compulsive drug seeking and using. Compulsions are defined generically as:

> repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases, the person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation . . . . By definition, compulsions are either clearly excessive or are not connected in a realistic way with what they are designed to neutralize or prevent.[47]

Addictive drug seeking and using is excessive, but it is surely realistically designed to prevent anxiety and distress among addicts for whom this is the primary motivation to take drugs. In either case, the compulsions of the person with Obsessive-Compulsive Disorder are distinguishable from the compulsions experienced by an addict.

Neither "compulsion," "compulsive," nor "craving" is among the terms included in DSM-IV-TR's "Glossary of Technical Terms."[48] On the other hand, the most recent edition of the *American Psychiatric Glossary* does define "compulsive" as follows: "Refers to intensity or repetitiveness of behavior

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43. *Id.* at 75.

44. *Id.* According to ICD-10, it is thus possible to be diagnosed as dependent in the absence of any analogue to "compulsive" behavior.

45. AM. PSYCHIATRIC ASS'N, *supra* note 2, at 663. This feature refers to "impulse control disorders not elsewhere classified," but DSM-IV-TR makes clear that other disorders, such as substance-related disorders, "may have features that involve problems of impulse control." *Id.*

46. *Id.*

47. *Id.* at 457; *see also id.* at 462 (listing the specific criteria).

48. *Id.* at 764–65.

rather than to compulsive behavior strictly defined. Thus, 'compulsive drinking' and 'compulsive gambling' refer to *cravings* that may be intense and often repeated, but they are not viewed as compulsions."[49] Craving is not defined, but this definition of "compulsive" does seem akin to the generic definition of addiction under consideration.

However it is defined, the crucial criterial term, "compulsive," is frustratingly vague and dependent primarily on assessment of subjective states. For example, DSM-IV-TR's criterion for Impulse-Control Disorder—the failure to resist a drive, impulse, or temptation to engage in harmful activity—does not disclose whether the person is unable or unwilling to resist or how hard it is to resist, nor does it indicate how harmful the act must be.[50] Further, the definition of Impulse-Control Disorder does not reveal how much inner tension and how much release-seeking behavior is necessary to qualify for the diagnosis of an impulse-control problem. ICD-10's criterion of an "often strong, sometimes overpowering" drive again does not specify how strong is strong enough and what is meant by overpowering. In the case of either of these criteria, if simply taking the drug repetitively (or, seemingly, taking it even once if it leads to a predictably harmful outcome) is sufficient, then the definition is essentially circular.

Such definitions will depend ultimately on a subjective assessment of the strength of desires and a normative assessment of when the seeking and using itself is sufficiently harmful to the agent to appear like a symptom, rather than like a bad or even harmless habit or a hobby. And how bad it will be for the agent will in turn depend a great deal on environmental variables that are entirely independent of brain states, such as the cost, availability, and legality of the substance.[51]

The definitional problems apparently can be remedied in various ways. First, compulsion (or addiction) could be defined operationally in terms of scores on various scales. There are many virtues to such an approach and it should be applauded. Even if various scales are reliable, however, validity problems will remain because there is no diagnostic gold standard. Moreover, there is no consensual agreement on the scales. Second, compulsion can be defined in terms of objective behavior—without regard to subjective experience—or in economic or rational choice terms, definitions that have theoretical, measurement, and esthetic advantages.[52] Indeed, there is clear

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49. AM. PSYCHIATRIC GLOSSARY 45 (Narriman C. Shahrokh & Robert J. E. Hales eds., 8th ed. 2003) (emphasis added).

50. Attempts to measure the strength of compulsions have been conceptually confused or methodologically suspect. *See* Stephen J. Morse, *From 'Sikora' to 'Hendricks': Mental Disorder and Criminal Responsibility*, *in* THE EVOLUTION OF MENTAL HEALTH LAW 129, 160–63 (Lynda E. Frost & Richard J. Bonnie eds., 2001).

51. *See* JON ELSTER, STRONG FEELINGS: EMOTION, ADDITION AND HUMAN BEHAVIOR 166–69 (1999); Alan Schwartz, *Views of Addiction and the Duty to Warn*, 75 VA. L. REV. 509, 517–23 (rejecting the "strong substance caused view" of addiction).

52. *See generally* GEORGE AINSLIE, BREAKDOWN OF WILL (2001) [hereinafter BREAKDOWN OF WILL]; GEORGE AINSLIE, PICOECONOMICS: THE STRATEGIC INTERACTION OF SUCCESSIVE

evidence that classical and operant conditioning best explain some addictive phenomena, and some researchers believe that any definition including subjective experiences such as craving will be circular. Nevertheless, a purely objective definition will fail to consider the addict's subjectivity, which most investigators and informed observers believe is crucial to adequate understanding.[53] If craving is crucial to the definition, including it does not threaten circularity because craving can exist in the absence of seeking and using behavior. Finally, addiction could be defined in terms of tolerance and withdrawal because these physiologically related states might be relatively objectively measured. Indeed, these criteria are included in both DSM-IV-TR and ICD-10, but they are neither necessary nor sufficient. Compulsive drug seeking and using can exist without them, and they can exist without accompanying compulsive activity and consequent harms.

In sum, present authoritative sources tell us, mostly conclusorily, that agents are driven, that they feel strong or overpowering desires, that they have intense cravings, and, least helpfully, that they are compelled. We are left where we began—with a descriptive phenomenological account of the addict's subjective mental states and behavior and common-sense understanding of those mental states and behavior.

Although the present understanding of craving and compulsion is often vague and inferential, the terms do have common-sense content and they are clearly both continuum concepts. Not all agents who experience craving and compulsion experience these states with the same intensity. If craving and compulsion may be predicates of an excuse for addiction-related action, it seems to follow that the intensity of these states would be crucial to responsibility assessment. But we do not have scientifically validated measures for the intensity of craving and compulsion, and even the discovery of clear biological (or other) causes for these states may not help in this regard. Craving and compulsion are intentional mental states. They take objects; people crave a specific thing or feel compelled to do a specific thing. A crucial feature about such states is that agents have privileged first-person access to them. Unless mental states are identical to and reducible to physical states—a highly controversial position in the philosophy of mind[54]—identification of biological causes will not indicate the subjective intensity of craving and compulsion. The upshot is that analysis of the responsibility of addicts for addiction-related behavior—however the addiction is caused—must at present rely on concepts

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MOTIVATIONAL STATES WITHIN THE PERSON 96–273 (1992). *But see* Gideon Yaffe, *Recent Work on Addiction and Responsible Agency*, 30 PHIL. & PUB. AFF. 178 (2001) (criticizing the usefulness of rational choice and related models of addiction for thinking about individual responsibility).

53. *See* ELSTER, *supra* note 51, at 62–65.

54. *See generally* PAUL M. CHURCHLAND, MATTER AND CONSCIOUSNESS 7–49 (rev. ed. 1988) (reviewing various approaches to understanding the mind-body problem). It is not known how the brain produces the mind**.** Until the mind-body problem is "solved," which will revolutionize our understanding of biology, such questions will remain. PAUL R. MCHUGH & PHILIP R. SLAVNEY, THE PERSPECTIVES OF PSYCHIATRY 11–12 (2d ed. 1998).

about the mental states of intentional agents that can be best evaluated using common sense.

B. Addiction and Individual Responsibility[55]

Once addicted, should addicts be responsible for use and further drug-related activity? By definition, addicts—or anyway most of them—experience subjective craving and compulsion to seek and use drugs. In some cases, withdrawal also might be feared, but most addicts know that the physical symptoms are manageable, and some of the "hardest" drugs addicts experience no physical withdrawal or any withdrawal syndrome at all.[56] Craving and compulsion drive the addict. If compulsion and lack of the capacity for rationality are the law's primary excusing conditions,[57] do craving and compulsion to use addictive substances or to engage in other addiction-related crimes provide a compulsion or rationality excuse?

1. The Internal Coercion Theory[58]

Although the biological models and the discovery of biological causes imply that the addict's symptomatic behaviors are mechanisms, this is simply not true. Compulsive states are marked by allegedly overwhelming desires or cravings, but whether the cravings are produced by faulty biology, including genetic predispositions or defects, faulty psychology, faulty environment, or some combination of the three, a desire is just a desire and its satisfaction by seeking and using is human action. The addict desires, broadly, either the pleasure of intoxication, the avoidance of the pain of withdrawal or inner tension, or both.

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55. Much of the analysis in this part necessarily involves philosophical, abstract concepts. The issue of responsibility is conceptual, moral, social, and political; it is not scientific, although scientifically discovered data and theories can provide important inputs to moral, social, and legal thinking. *See generally* Comm. on Addictions, *supra* note 21; Yaffe, *supra* note 52 (reviewing and analyzing empirical and philosophical concepts). Two recent, edited collections concerning genetics and criminality are excellent sources concerning genetics and responsibility, although neither is specifically focused on addiction. *See* Dan W. Brock & Allen E. Buchanan, *The Genetics of Behavior and Concepts of Free Will and Determinism*, *in* GENETICS AND CRIMINALITY: THE POTENTIAL MISUSE OF SCIENTIFIC INFORMATION IN COURT 67 (Jeffrey R. Botkin, William M. McMahon & Leslie Pickering Francis eds., 1999) (see especially); GENETICS AND CRIMINAL BEHAVIOR (David Wasserman & Robert Wachbroit eds., 2001). See *supra* Part II for highly sophisticated contributions concerning responsibility.

56. Withdrawal from cocaine, for example, produces dysphoric mood rather than the uncomfortable physical symptoms that accompany opiate withdrawal. Margaret Haney, *Neurobiology of Stimulants*, *in* THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF SUBSTANCE ABUSE TREATMENT 31, 36–37 (Marc Glanter & Herbert D. Kleber eds., 3d ed. 2004). Some "hard" drugs, such as PCP, have no withdrawal syndrome. Shelly F. Greenfield & Grace Hennessy, *Assessment of the Patient*, *in id*. at 101, 112.

57. There is no uncontroversially correct descriptive model of the law's responsibility doctrines and practices. Some model must implicitly or explicitly be used to assess responsibility, however. I have argued that the model being used is the best overall description of our law and is normatively desirable. *See infra* Part IV; *see also* Morse, *supra* note 16; Morse, *supra* note 24. The general model may not convince everyone concerning all details, but it is clearly a standard type of view and not idiosyncratic.

58. *See generally* Stephen J. Morse, *Uncontrollable Urges and Irrational People*, 88 VA. L. REV. 1025, 1054–63 (2002) (explaining the meaning of internal compulsions generally).

The addict believes that using the substance will satisfy the desire and consequently forms the intention to seek and to use the substance.

To attempt to demonstrate that people suffering from compulsive states are similar to mechanisms, the following type of analogy is often used. Imagine that a person is hanging by the fingernails from a cliff over a very deep chasm. The hapless cliffhanger is strong enough to hold on for a while, but not strong enough to save her life by pulling herself up. As time passes and gravity and muscle physiology do their work, she inevitably weakens and it becomes harder and harder to hang on. Finally it becomes impossible and the cliffhanger falls to her death. We are asked to believe that the operation of compulsive desires or cravings is like the combined effect of gravity and muscle physiology. At first the hapless addict can perhaps resist, but inevitably she weakens and satisfies the desire for drugs.

Brief reflection demonstrates that the analogy is flawed as an explanation of why compulsive states are "just like" mechanisms. Unlike action to satisfy a desire, the fall is a genuine mechanism. Holding on indefinitely is physically impossible and the ultimate failure of strength is not intentional. Imagine the following counterexample: A vicious gunslinger trails the addict closely and threatens to kill her instantly if she seeks or uses drugs. Assuming that the addict wants to live as much as the cliffhanger does, no addict would yield to the desire.[59] Conversely, even if the same gunslinger threatened to shoot the cliffhanger immediately if she started to fall, she will fall every time. Of course, our liberal society does not force or even permit addicts to employ such a self-management technique, but the counterexample, like Leroy Powell's case,[60] indicates that the addict's behavior is not a mechanism.

An addict is not a cliffhanger, of course, so let us consider some closer analogies, such as a powerful, persistent itch, or an increasingly full bladder, or the motor and verbal tics of those suffering from Tourette's Disorder.[61] It can be damnably hard not to scratch an itch, even if it is contraindicated. An increasingly full bladder can cause dreadful discomfort and an overwhelming feeling of the need to void. The premonitory build up of tension that precedes

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59. Addicts simply need sufficiently good reason not to yield. One might object that they only need sufficiently good inducement, rather than good reason, but in this case the inducement is in fact a good reason. Another possibility is that the variable motivating abstinence is not a good reason, but simply one that is so salient that it creates motivational force. This is undoubtedly possible, but in most cases of genuine addiction, what induces abstinence will almost certainly be a good reason, rather than simply a salient rationale. Geoffrey Sayre-McCord, Professor of Philosophy, University of North Carolina, provided helpful insight on these points.

60. *See* Powell v. Texas, 392 U.S. 514, 517–18 (1968) (suggesting that Powell was able to stop drinking the day of his trial for public drunkenness because he knew that he had to be in court).

61. The itch example was given by George Ainslie, Chief of Psychiatry at the Coatesville, Pennsylvania Veterans Administration Hospital. Dr. Ainslie is a leading theorist and researcher on addictions. *See generally* AINSLIE, *supra* note 51. The bladder example was first suggested by an anonymous participant at a conference. Jon Elster also uses it. On Tourette's Disorder, see Charles W. Popper, G. Davis Gammon, Scott A. West & Charles E. Bailey, *Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence*, *in* TEXTBOOK OF CLINICAL PSYCHIATRY, 833, 906–11 (Robert E. Hales & Stuart C. Yudofsky eds., 4th ed. 2003).

and is relieved by tic behavior among those suffering from Tourette's is usually intense and far more bothersome than the tics themselves. In all cases, the "pressure" to satisfy the desire, to end the discomfort, can be immense. But even in such cases the agent will be to some degree reward-sensitive or reason-responsive. The gun at the head will work again. If people with itches, full bladders, or pre-tic tension satisfy the desire to rid themselves of the itch, discomfort, or tension, surely their behavior will be action and not mechanism.[62]

Still, although the addict's behavior is not mechanism, perhaps not seeking and using is as hard as not scratching an itch, voiding one's bladder, or engaging in tic behavior. Is it fair to expect the addict to self-regulate successfully in ordinary circumstances that do not permit brute techniques, such as threatening oneself with instant death, just in case one lapses? Is yielding to the desire an appropriate basis for blame and punishment, especially in extreme cases? Perhaps, after all, drug-related activity is sufficiently like mechanistic movement to qualify for an excuse, but this requires an argument rather than an analogy. Too often we are seduced by medical metaphors that strongly suggest mechanism. Nevertheless, the disease model and ordinary language—the addict allegedly "can't help using," or is "impelled to use," or, more bluntly, is "compelled to use"—suggest that addiction primarily produces a control or volitional problem.

Volition is a vexing foundational problem for philosophy, psychology, and law.[63] Even if "black box" models of control problems seem to explain the phenomena deemed addiction, the law's concept of the person as a conscious, intentional agent implies that such models cannot provide the law with adequate guidance either to decide if an excuse is warranted either in general or in individual cases. Any model must translate into terms of human agency.

Consider some alternatives. If one adopts Professor Michael Moore's influential, widely-noticed contention that volition is a functional mental state of executory intention,[64] the problem of volition disappears because virtually no addict has a volitional problem. Their wills translate their desires for the drug into the necessary action quite effectively. Indeed, on this account of the will, almost no intentional conduct will raise a problem of volition.[65] Moore's account is persuasive, but like all accounts of the philosophical foundations of action, it is controversial. Some competitors that consider volition a species of desire, a view that Moore and others reject,[66] may raise volitional problems in

62. If a full bladder finally simply "overflows" because the pressure prevents the agent from controlling the sphincter muscles, voiding is purely a mechanism.

63. *See* Bernard J. Baars, *Why Volition is a Foundation Problem for Psychology*, 2 CONSCIOUSNESS & COGNITION 281 (1993); Morse, *Culpability and Control*, *supra* note 25, at 1595–97.

64. MICHAEL S. MOORE, ACT AND CRIME: THE PHILOSOPHY OF ACTION AND ITS IMPLICATIONS FOR CRIMINAL LAW 113–65 (1993).

65. *Id.*

66. *E.g.*, GALEN STRAWSON, FREEDOM AND BELIEF 66–67 (1986) (citing Kant).

the case of addicts.[67] Unless these alternatives can be reduced to ordinary language concepts that apply to human agency, however, it will be impossible for legislatures and courts to resolve disputes about the metaphysics of mind and action rationally.[68]

An "internal coercion" model is one possible explanation of a control or volitional excuse based on "disorders of desire."[69] The model employs a moralized, common-sense approach that is analogous to the criminal law excuse of duress and that requires no implausible, unverifiable empirical assumptions about how the mind works.[70] Thinking about duress is fundamental to this approach. Consequently, its criteria will be considered before turning to whether the model can be applied to addictions.

Duress obtains if the defendant is threatened with the use of deadly force or grievous bodily harm against himself or another unless the defendant commits an equally or more serious crime, and a person of reasonable firmness would have been "unable to resist" the threat.[71] In other words, an agent faced with a particularly "hard choice"—commit a crime or be killed or grievously injured—is legally excused if the choice is too hard to expect the agent to buck up and obey the law. The defense, however, is not based on empirical assumptions about the subjective capacity of an individual agent to resist threats; it is moralized and made objective.[72] For example, the defense is not available to a defendant allegedly "unable" to resist if the threats were less than death or grievous bodily harm or if a person of *reasonable* firmness would have been able to resist.

The moralized criterion of the person of reasonable firmness necessary to support the excuse of duress appears to risk unfairness. Suppose a person would find it extraordinarily difficult to resist threats that a person of

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67. *See, e.g.*, WILLIAM CHARLTON, WEAKNESS OF THE WILL: A PHILOSOPHICAL INTRODUCTION (1988) (discussing competing accounts of weakness of the will); R. Jay Wallace, *Addiction as Defect of the Will: Some Philosophical Reflections*, 18 L. & PHIL. 621 (1999) (see especially Section 2).

68. A classic, well-known example of a theory of volition that can be understood in ordinary language terms and that has therefore received much attention in the legal as well as philosophical literature is Harry Frankfurt's hierarchical theory. HARRY G. FRANKFURT, THE IMPORTANCE OF WHAT WE CARE ABOUT: PHILOSOPHICAL ESSAYS 11, 24 (1988). For reasons considered elsewhere, however, this seemingly attractive model does not succeed. *See* Morse, *Culpability and Control*, *supra* note 25, at 1626–28.

69. The next subsection suggests that irrationality provides a better explanation of why we might excuse or mitigate the responsibility of an agent suffering from a disorder of desire such as addiction.

70. The analysis in this subsection has been enormously influenced by Alan Wertheimer's treatment of similar issues. *See* ALAN WERTHEIMER, COERCION (1987). It is assumed that duress can sometimes be an excusing condition. *See* Joshua Dressler, *Exegesis of the Law of Duress: Justifying the Excuse and Searching for its Proper Limits,* 62 S. CAL. L. REV. 1331 (1989)**.** R. Jay Wallace believes that it is always a justification. *See* WALLACE, *supra* note 6, at 144–47. The differences are discussed in the text *infra*.

71. MODEL PENAL CODE § 2.09 (1962).

72. Using the term "objective" is not meant to suggest that the "person of reasonable firmness" criterion has a reality independent of our practices that can be discovered by reason or empirical investigation. It is only meant to be a thoroughly normative standard that expresses what we all expect of each other in our legal and moral culture.

reasonable firmness could resist. Under such conditions, criminal penalties would be retributively unjust because a person does not deserve punishment for conduct that is so difficult for that agent to avoid. Moreover, specific deterrence is bootless in such cases. A purely consequential view might justify punishment to buck up the marginal people, but only at the cost of injustice to those unable to resist. Because fault is a necessary condition for blame and punishment in our system, denying the defense would be unjust. Those who take this position should argue for a purely subjective view of the duress excuse, which would require difficult empirical assessment of the defendant's capacity to resist. This standard would be a nightmare to adjudicate, but worth the effort if it were necessary to avoid injustice.

There is a good argument, however, that the moralized, objective standard that uses the person of reasonable firmness as the criterion is not unfair. If a person is threatened with death, for example, the defense of duress should be potentially available unless the balance of evils is so remarkably negative that every person would be expected to resist. In all other cases, the question would at least "go to the jury." Thus, there will be few cases involving sufficiently serious threats in which the person incapable of resisting would lose the potential defense. The person genuinely incapable—if any there be—of resisting even when the threats are relatively mild—say, kill or be touched—will almost certainly be a person with irrational fears that will qualify for some type of irrationality defense. Duress might not obtain, but exculpation will be available on other grounds.

The formulation, "unable to resist," has the unmistakable implication of mechanism. Unless *force majeure* or genuine mechanism is at work, we virtually never know whether the agent is in some sense genuinely unable or is simply unwilling to resist, and if the latter, how hard it is for the agent to resist. In the present state of knowledge, research evidence concerning the characteristics that help people maintain control when faced with temptation or experiencing impulses is no more than a general guide.[73] No metric and no instrumentation can accurately resolve questions about the strength of craving and the ability to resist. This was in large part the reason that both the American Psychiatric Association and the American Bar Association recommended the abolition of the control or volitional test for legal insanity in the wake of the ferment following the *Hinckley*[74] verdict.[75] Moreover, courts

73. ROY F. BAUMEISTER, TODD F. HEATHERTON & DIANNE M. TICE, LOSING CONTROL: HOW AND WHY PEOPLE FAIL AT SELF-REGULATION 242–56 (1994) (considering self-regulation techniques and distinguishing underregulation, in which the agent often actively participates, and misregulation, in which the agent seldom actively participates). *See generally* BREAKDOWN OF WILL, *supra* note 52 (applying hyperbolic discounting theories to problems of willpower and loss of control); ALBERT BANDURA, SELF-EFFICACY: THE EXERCISE OF CONTROL (1997) (providing an overview of human agency and presentation of "self-efficacy" theory); HOWARD RACHLIN, THE SCIENCE OF SELF-CONTROL (2000) (providing a review of research and theoretical account of self-control based on "teleological behaviorism").

74. United States v. Hinckley, 525 F. Supp. 1342 (D.C. 1981).

faced with deciding whether to adopt a volitional test after *Hinkley* refused to do so for the same reason.[76] If strength of craving or of resistance are to be the touchstones, legal decisionmakers will have to act with little scientific guidance and lots of common sense.[77]

The analogy often used to demonstrate that craving is like duress is that the intense cravings or desires of "compulsive" states are like an "internal" gun to the head. The sufferer's fear of physical or psychological withdrawal symptoms and of other dysphoric states[78] is allegedly so great that it is analogous to the "do-it-or-else" fear of death or grievous bodily injury that is necessary for a duress defense. Yielding to a compulsive desire, a craving, is therefore like yielding to a threat of death or grievous bodily harm.[79] The argument is that we cannot expect a person of reasonable firmness not to yield in the face of such an internally generated hard choice, much as we cannot expect such a person not to yield in the face of an external threat of death or grievous bodily harm.

The analogy is attractive, but theoretically and practically problematic. First, the analogy suggests no problem with the defender's will, which operates effectively to execute the intention to block or to remove the dysphoria.[80] Further, it is entirely rational, at least in the short-term, to wish to terminate ghastly dysphoria, even if there are competing reasons not to, such as criminal sanctions or moral degradation. And it is simply not the case that addicts always act to satisfy their cravings because they fear dysphoria. Many just yield because it is unpleasant to abstain, not because they substantially fear dysphoria. In addition, the phenomenology of the sufferer's response to craving, unlike the phenomenology of the victim threatened by death, often is not, and perhaps never is, clear or the product of unitary, simple causes. Suppose, for example, that the primary motive is the pleasure or satisfaction of yielding or that such pleasure is an important, additional motive. The

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75. *See* AM. BAR ASS'N CRIMINAL JUSTICE STANDARDS COMM., ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS 330, 339–42 (1989); AM. PSYCHIATRIC ASS'N, INSANITY DEFENSE: POSITION STATEMENT (1982).

76. *E.g.*, United States v. Lyons, 731 F.2d 243 (5th Cir. 1984) (en banc). The Court also held that narcotics addiction alone, without other physiological or psychological involvement, was not a mental disease or defect for the purpose of raising the insanity defense. *Id.* Presumably, the court meant physiological or psychological effects that were not per se part of the criteria for addiction. Congress later abolished the volitional wing of the insanity defense in federal criminal trials and retained only a cognitive test for legal insanity. Insanity Defense Reform Act of 1984, 18 U.S.C. § 17 (2000).

77. For example, one writer explains, "The strength of the craving may be gauged by how willing the person is to sacrifice other sources of reward or well-being in life to continue engaging in the addictive behavior." Dennis M. Donovan, *Assessment of Addictive Behaviors: Implications of an Emerging Biopsychosocial Model*, *in* ASSESSMENT OF ADDICTIVE BEHAVIORS 3, 6 (Dennis M. Donovan & G. Alan Marlatt eds., 1988)[hereinafter Donovan, *Assessment of Addictive Behaviors*]. Although written by an estimable researcher, it is no more than an operationalized, common-sense measure.

78. *See* AM. PSYCHIATRIC ASS'N, *supra* note 2, at 663 (stating that most "impulse-control disorders" include an increase of tension and arousal before committing the harmful act).

79. In most cases of "impulse-control disorders," there is an experience of pleasure, satisfaction, or relief after committing the impulsive act. *Id.*

80. FINGARETTE & HASSE, *supra* note 26, at 61.

possibility of pleasure seems more like an offer than a threat, and offers expand rather than contract freedom. The strong desire for pleasure is not a hard-choice excusing condition in law or morals.

Assuming that fear of dysphoria is a sufficient motive and that the analogy to the fear of death or grievous bodily harm is initially plausible, two problems remain: assessing the strength of the fear and deciding what degree of fear of dysphoria is sufficient to excuse what types of conduct. Based on ordinary experience and common sense, the criminal law uses threats of death or grievous bodily harms as objective indicators of the type of stimulus that would in ordinary people create sufficient hard choice to justify an excuse. Of course, people subjected to such threats will differ markedly in their subjective fear responses and in their desires to live or to remain uninjured, but ordinary, average people will have very substantial fear and find the choice to resist very difficult.[81] We have all experienced dysphoric states, and many have experienced intense dysphoria, but dysphoria as a source of present and potential pain is more purely subjective than death or grievous bodily injury. Consequently, assessing the average or ordinary intensity of craving or inner tension, including seemingly strong states, is simply more difficult than assessing the fear of death or grievous bodily injury. Focusing on more objective markers of compulsive states, such as physical withdrawal symptoms, will surely help, but fear of such symptoms is unlikely to support an excuse.

Fear of the physical symptoms of withdrawal from most drugs is not likely to be as intense as the fear of death or grievous bodily harm because in most cases withdrawal is not terribly painful—withdrawal from heroin is often likened to a bad flu—and can be medically managed to reduce the discomfort.[82] Withdrawal from alcohol dependence can be extremely severe, but it, too, can be medically managed, and because alcohol is freely and inexpensively available for adults, those who fear withdrawal and do not want treatment seldom need to commit crimes or other wrongs to obtain alcohol to avoid withdrawal.

Dysphoric mental or emotional states are surely undesirable, but does their threat, especially if medical management is available, produce a sufficiently hard choice to warrant an excuse? The answer to this question is not obvious, but perhaps at the extreme they do. People suffering from severe depressive disorders, for example, report subjective pain that is apparently as great and enduring as the reported pain from many forms of grievous bodily harm, and sometimes depressed people kill themselves to avoid the psychological pain. For another example, some people addicted to alcohol who are being treated with a drug that makes them dreadfully sick if they ingest any alcohol, including

81. The analysis could apply to moral dilemmas that the criminal law does not address. Imagine a person who possesses a monetarily worthless locket that contains an equally financially worthless but emotionally priceless memento, say, a strand of a sainted parent's hair. One could easily imagine that a threat to destroy the locket might morally excuse quite serious property crime and perhaps crimes against the person, although the criminal law would recognize no excuse in this case.

82. *See* JOHN KAPLAN, THE HARDEST DRUG: HEROIN AND PUBLIC POLICY 35–36 (1983).

trace amounts, will "drink through" the miserable sickness.[83] These examples and common sense suggest that fear of or aversiveness to psychologically dysphoric states may be very strong, indeed.[84] But is it as strong as the fear of death?

Even assuming that the feared dysphoria of unconsummated cravings can be substantial, it will likely seldom be as severe as the fear of death or grievous bodily harm. If this is right and assuming, too, that we could reliably assess the fear of dysphoria, few addicts would succeed with a hard-choice excuse. On the other hand, if the drug-related activities were simple possession for personal use and use itself, then perhaps the justification of necessity should obtain.[85] Even if the harm of such activity is less than the harm of dysphoria, however, the law would hold most addicts responsible for becoming addicted and thus for placing themselves in the situation that created the need for the defense. The law disallows the justification in such cases.[86] Finally, even if addicts were not responsible for becoming addicted, all legislatures would today resist permitting a justification for possession and use on policy grounds and would surely reject an excuse for other, possibly related crimes, such as theft or robbery, to pay for drugs. The disease model is powerful, but the moral failure model is resilient.

In sum, the internal coercion or duress approach uses understandable terms and has a moral basis derived from a defense that the criminal law and ordinary morality already accept. Nevertheless, currently insurmountable practical problems beset attempting to assess the appropriateness of an excuse in individual cases. What is more, thinking about excuse in terms of control difficulties inevitably will invite misleading metaphorical thinking about mechanism and expert testimony that is little more than moral judgment wrapped in the white coat of allegedly scientific or clinical understanding. The law should not adopt an internal coercion excuse.

2. The Irrationality Theory

Irrationality is the most straightforward, persuasive explanation of why some addicts should perhaps be excused. Moreover, irrationality will excuse any addict who may apparently qualify under the internal coercion theory. If the craving sufficiently interferes with the addict's ability to grasp and be guided by reason, then a classic irrationality problem arises and there is no need to resort to compulsion as the ground for excuse. Finally, it is simply more

83. ARNOLD M. LUDWIG, UNDERSTANDING THE ALCOHOLIC'S MIND: THE NATURE OF CRAVING AND HOW TO CONTROL IT 58–59 (1988). Such cases are surely rare, however, and most alcoholics who wish to drink either discontinue their aversive therapy or find ways to disable its effect. Interestingly, some East Asian populations have a genetically caused variation in the enzymes that metabolize alcohol that create effects of ingestion similar to the effects of the aversive therapy medication. Alcohol addiction is consequently infrequent in such populations**.** Nestler, *supra* note 3, at 277.

84. *See* Donovan, *Assessment of Addictive Behaviors*, *supra* note 77.

85. *E.g.*, MODEL PENAL CODE § 3.02 (1962).

86. *See, e.g.*, N.Y. PENAL LAW § 35.05 (McKinney 2003) (allowing the defense as an emergency measure to avoid an imminent harm if the situation occurred "through no fault of the actor").

practicable to assess rationality than to assess the strength of compulsive desires.

How does it feel to crave intensely? The subjective experience of addicts is diverse, but a modal tale may be useful. Despite different historical pathways to addiction, descriptions of the subjective experience are broadly of a piece,[87] although different descriptors and metaphors are and could be used. The story is not meant to include all the features of the addictive process; rather, it is an approximation of the subjective experience preceding use that may bear on responsibility.

Between episodes of use of the substance, the addict commonly experiences a build up of tension, irritation, anxiety, boredom, depression, or other dysphoric states. As time passes since the last use, these dysphoric states typically become stronger, more persistent, more intense, and more demanding. In some cases, the build-up is described as sheer desire, sheer wanting. As the wanting remains unsatisfied, increased dysphoric states or, in some cases, excitement, accompany the wanting. For illicit-drug addicts, anxiety or fear about obtaining the substance often adds to the dysphoria.

At some point, the addict metaphorically, and in some cases literally, can think of nothing but the desire to use the substance. One informant described the desire like "a buzzing in my ears that prevents me from focusing." It is like an extreme version of being dehydrated or starved: the addict can ordinarily think of nothing except getting and using the stuff. It is like the moment just before orgasm during an episode of exceptional excitement, but usually without the pleasurable feeling of sexual excitement. There is only one tune or story in the addict's head and nothing else drives it out.[88] When the addict can not get the tune out of his head, it is very difficult to concentrate the mind on the good reasons not to use, especially because, in almost all instances, there is no police officer at the elbow or other available "self-management technique" sufficiently powerful to motivate the addict to think clearly about drug-related activity. Fundamental components of rationality—the capacities to think clearly and self-consciously to evaluate one's conduct—are compromised. The agent may not recognize the various options at all or may not be able coherently to weigh and assess those that are recognized. For moral and legal purposes, however, the precise mechanisms by which addiction can compromise rationality are less important than the clear evidence that it can do so.[89] On the other hand, the

87. *See, e.g.*, Donovan, *Assessment of Addictive Behaviors*, *supra* note 77, at 5–11 (describing "commonalities across addictive behaviors").

88. *See, e.g.*, Michael B. Ross, *It's Time for Me to Die: An Inside Look at Death Row*, 26 J. PSYCHIATRY & L. 475, 482–83 (1998) (providing a first person account given by a death row inmate with persistent, allegedly overwhelming urges to degrade, rape, and kill, who describes the urges as a song one cannot get out of one's head). This example does not involve addictions, of course, but certain disorders of sexual desire, the paraphilias, produce impulse control problems similar to those associated with substance-related problems and impulse control disorders generally. AM. PSYCHIATRIC ASS'N., *supra* note 2, at 663.

89. *See* ELSTER, *supra* note 51, at 169–79 (reviewing the potential mechanisms through which cravings resulting from drug addiction can affect rational choice); Peter W. Kalivas, *Choose to Study*

addict's characteristic ambivalence about addiction suggests that addicts recognize that they have good reason to stop, at least during lucid or inter-use intervals.[90]

The degree to which the general capacity for rationality is compromised can vary widely among addicts. The modal tale is told as an extreme case and is anyway only an approximation. Still, addiction can compromise rationality and therefore can potentially excuse drug-related activity, especially for those most severely affected. Thus, the question remains whether the law should consider addiction as a potential excuse. This is an important question for social and legal policy because drugs are a factor in much criminal conduct. Possession and use offenses are rampant, and in most big cities, well over half of all people arrested for felonies test positive for addictive substances.[91] Many of these are surely addicts. Society may believe that it is fair to blame and punish them, but is it?

Thus far, the assumption has been made that addicts are not responsible for becoming addicted. At this point, this assumption will be relaxed and it will be assumed instead that many were responsible because prior to addiction they retained general normative capacity and because they knowingly, albeit with imperfect information, placed themselves at risk for becoming addicted. Moreover, some people may become addicted intentionally. Of course, because the majority of users of any substance do not become addicts, when future addicts use substances prior to addiction, virtually none is certain to become addicted. At most, they are consciously aware of the risk,[92] especially if they are aware of being in a high-risk group, but conscious awareness of substantial risk is sufficient to support ascriptions of responsibility. At the very least, an addict becomes addicted negligently. Some addicts are not at all responsible for their condition because they genuinely became addicted before late adolescence,

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Choice in Addiction, 161 AM. J. PSYCHIATRY 193 (2004) (stating that at some point in a developing addiction disorder, decisionmaking ability becomes compromised); Louk J.M.J. Vanderschuren & Barry J. Everitt, *Drug Seeking Becomes Compulsive After Prolonged Cocaine Self-Administration*, 305 SCIENCE 1017, 1017 (2004) ("Addicts display drug-dominated, inflexible behavior and are unable to shift their thoughts and behavior away from drugs and drug-related activities," which increases with prolonged use).

90. This point is courtesy of George Ainslie, Chief of Psychiatry at the Coatesville, Pennsylvania Veterans Administration Hospital.

91. PAIGE M. HARRISON & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2002, 10, 11 (2003) (finding that 20.4% of sentenced state inmates in 2001 incarcerated for drug offenses; 55% of sentenced federal inmates incarcerated for drug offenses); ZHANG, *supra* note 2; *see also* DORIS JAMES WILSON, BUREAU OF JUSTICE STATISTICS, DRUG USE, TESTING, AND TREATMENT IN JAILS 1 (2000) (finding that in 1998, 70% of jail inmates had used drugs regularly or had committed a drug offense).

92. This language tracks the Model Penal Code's definition of recklessness, which is defined as conscious awareness that one's conduct is producing a substantial and unjustifiable risk of some harm. MODEL PENAL CODE § 2.02(2)(c) (1962). In the case of licit substances, such as alcohol and nicotine, the risk may not be legally *un*justified, however, because using and being addicted to these substances are not unlawful.

because they were involuntarily addicted, or for some other responsibility-diminishing reason. Such addicts are a minority, however.[93]

Whether or not addicts were responsible for becoming addicted, they will not lack mens rea for their substance-related criminal activity.[94] Virtually all potential addicts are consciously aware of the risk that if addicted they will persistently and intentionally seek and use substances. Nevertheless, the previous conscious awareness of this risk is distinguishable from forming the intention pre-addiction to seek and use after becoming addicted. For most addicts, however, there will be no mens rea problem when they seek and use. They are not automatons and they do form the intent to buy, possess, and use. In most cases of serious criminal wrongdoing, the potential addict may be unaware of the risk of committing such offenses unless the addict has a history of such wrongdoing. Even if this is true, however, there still will be no mens rea problem. An addict who burgles, robs, or kills surely forms the intent to do so. In the narrow legal sense, most addicts have the true purpose to engage in their drug-related conduct. If they deserve mitigation and excuse, it is because they are not fully rational, not because they lack the mental state required by the definition of the offense.

As a result of addiction, some addicts are sufficiently irrational to warrant mitigation or excuse at the time they commit their substance-related crimes. Should they be held responsible nonetheless? Two theories suggest in general that virtually all should be. The first is that by experimenting, the addict knowingly took the risk that she would become irrational, including the possibility that the irrationality would operate specifically in contexts involving substance-related behavior. The second and more convincing theory is that almost all addicts have lucid, rational intervals between episodes of use during which they could act on the good reasons to seek help quitting or otherwise to take steps to avoid engaging in harmful drug-related behavior. This situation has been termed a case of potential diachronic self-control because the person knows that at a later time she will be in a state of non-responsible irrationality.[95] Again, the ambivalence about addiction that characterizes addicts implies that they are capable of and do recognize these good reasons during their lucid intervals. Even if some addicts are unable to think rationally when they are in a

93. Assuming that addicts are responsible for their condition, an interesting question is whether addiction is just a status, as *Robinson v. California*, 370 U.S. 660 (1962), held, or whether it necessarily includes seeking and using behavior, as the definition considered above requires. Because the law is unconcerned with status per se, the criminality or immorality of simply being an addict will not be addressed.

94. The major exception will be cases in which the addict offends while in a state of unconsciousness or blackout induced by substance use. Most jurisdictions would permit only limited use of such evidence to negate mens rea and some would not permit it at all. The Supreme Court has declared constitutional the total exclusion of intoxication evidence, even when it is undeniably relevant and probative of culpability. Montana v. Egelhoff, 518 U.S. 37 (1996).

95. JEANNETTE KENNETT, AGENCY AND RESPONSIBILITY: A COMMON-SENSE MORAL PSYCHOLOGY 134–35 (2001).

state of intense craving, they are capable of rationality in refractory periods and have a duty to take steps to avoid future offending.

Both theories are potentially subject to the same objection, however. Addiction can become an entire lifestyle and the consequences of prolonged use of substances can so debilitate addicts physically and psychosocially that some addicts have exceptional difficulty at all times exercising substantial rationality concerning their status and behavior. Although potential addicts may be aware of the risk of irrationality, they may not be fully aware of the risk of extreme irrationality that can arise in some cases. In such cases, perhaps, one cannot find responsibility for extreme irrationality by referring back to pre-addiction, knowing conduct, or by considering quiescent intervals. In cases of extreme debilitation, the intervals between episodes of use may not be fully rational.

The foregoing objection does not seem decisive, however. First, in those few cases in which prolonged drug use produces a permanent, major mental disorder that compromises rationality at the time of criminal conduct, the addict will have available a traditional insanity defense based on "settled insanity" resulting from the use of intoxicants.[96] But except in such rare cases, most addicts' rational intervals are probably sufficiently rational to hold them largely or fully responsible for diminishing their own rationality at the time of use or other drug-related crimes. In addition, as a result of both street wisdom and personal history, experienced addicts typically know during these intervals both what treatment alternatives are available and the type of criminal behavior beyond seeking and using in which they are likely to engage. Indeed, much of the further criminal activity probably takes place during the rational intervals and involves harm to others, which carries greater criminal penalties, giving the addict even stronger self- and other-regarding reasons not to offend than in the case of personal possession and use.

Finally, suppose one concludes that some addicts deserve mitigation or excuse for at least some criminal conduct. The previous subsection on the internal coercion theory suggests that irrationality would excuse any addict that the internal coercion theory might fairly excuse. The argument, in brief, is this: A person driven crazy by fear is crazy. Or, in the alternative, people so fearful of mild dysphoric states that they appear incapable of bucking up when reasonable people would are irrationally fearful. Any plausible story about allegedly compulsive cravings motivating the criminal conduct, especially in cases of serious crime, also will be a story in which the addict is less than fully rational or not rational at all. In such cases, irrationality would be the appropriate excusing claim; there would be no need to resort to problematic internal coercion.

96. It is assumed that almost all jurisdictions would permit this defense for cases in which the settled insanity resulted from illicit drugs. *See* WAYNE R. LAFAVE, CRIMINAL LAW 481–82 (4th ed. 2003).

The conclusion is that most addicts are responsible for seeking and using and almost none should be excused for further criminal activity, and especially not for serious wrongdoing. There are simply too many periods of rationality and there is simply too much awareness of alternative possibilities to permit excuse in more than a small number of cases.[97]

C. "Social Responsibility"

Socioeconomic arrangements, culture, life stories, legal regulation, and other "external" causal variables can seem much to blame for addiction and its consequences. Even if most addicts are responsible for becoming addicted and for their behavior while addicted, whether one becomes an addict and how one lives as an addict are not solely due to the intentional conduct of an agent who becomes an addict.

Consider the following examples. It is entirely understandable that people living in communities of deprivation, with few life chances, may find a life of addiction preferable to the misery of an impoverished straight life. Some subcultures particularly encourage and celebrate the use of potentially addictive substances, increasing the risk of addiction among members of that subculture. For those who have lived lives of desperation or who suffer from psychological miseries for any reason, substance use can be a welcome escape. Finally, legal regulation can affect the probability of addiction, the lifestyles of addicts, and the further behavioral consequences of addiction. It is more difficult to bum a dime bag than to bum a smoke or to cadge a free drink, even from friends, and the addict can never be sure that a dealer is not an undercover narc, an informant, or cutting the dope. Lawful availability and price affect rates of consumption, the development of informal customs and conventions for controlled use, the health, safety, and legal dangers of seeking and using drugs, and the probability that other criminal behavior beyond possession and use will occur as a result of addiction. Explanations such as these, especially when considered in the context of a sympathy-arousing life history, can tug at our hearts and influence our responsibility attributions. As Gary Watson concluded in his discussion of the case of a murderer who had suffered a dreadful childhood, in many cases our reaction will be, "No wonder."[98]

How should we respond to powerful social explanations? Social variables account undeniably for a great deal of the variance in addictions and related

97. Part IX.A *infra* considers the case for mitigation in more detail. This part also suggests that current criminal law overcriminalizes much drug-related activity. Even if addicts might be responsible for that activity, it does not follow that it is sensible to criminalize it.

98. Gary Watson, *Responsibility and the Limits of Evil: Variations on a Strawsonian Theme*, *in* RESPONSIBILITY, CHARACTER, AND THE EMOTIONS: NEW ESSAYS IN MORAL PSYCHOLOGY 256, 275 (Ferdinand Schoeman ed., 1987). Watson's description is of the life of Robert Alton Harris, a notorious multiple murderer who seemed to have no empathy for other people. Indeed, his cellblock mates on death row detested him. Yet if one reads his life history, it is difficult not to have at least a modicum of sympathy for Harris and to think that a dreadful outcome was entirely understandable for reasons in no way Harris' fault. *Id.*

behavior, and many of these variables are potentially modifiable by sound social policy. For example, millions of lives will be affected by resolution of the current debates concerning decriminalization of illicit drugs,[99] differential penalties for essentially similar substances such as crack and powdered cocaine, the propriety of needle exchanges, and whether nicotine should be regulated by the Food and Drug Administration. A just society should try to minimize the inevitable ill effects of its policies. Nonetheless, crimes and moral wrongs are ultimately committed by individual agents, and social causal variables, or any other kind of causal variables, cannot excuse addicts who are individually responsible without threatening all individual responsibility.[100]

All behavior is caused by innumerable variables over which we have no control. Some causal stories surely arouse more sympathy than others, but sympathy and an unfortunate life history are not excusing conditions per se. One may wish to consider such variables for disposition on consequential grounds or as an expression of mercy, but they do not excuse unless they produce sufficient irrationality or a sufficiently hard choice. Focusing on individual responsibility should not blind us to the remediable causes of wrongdoing and should not diminish justifiable sympathy for wrongdoers, but neither should explanations and sympathy undermine our view that most wrongdoers are responsible agents.

IX

PROPOSALS: DIMINISHED RESPONSIBILITY, DRUG TREATMENT, & SENSIBLE CRIMINAL JUSTICE

Three potential legal reforms might produce more proportionate blame and punishment for addiction-related offenses and might reduce addiction-associated costs overall. First, the criminal law should adopt a generic partial excuse to crime that might well apply to cases of addiction-related crime. Second, forced treatment of addicts using the leverage of the criminal law would be fair and likely to be effective. Last, sensible criminalization policy in response to addiction and addiction-related crime would have profound effects.

A. Diminished Responsibility

Some addicts might not be responsible for seeking and use or for further drug-related or drug-affected activity because they are not rational or not fully rational, or perhaps, because they faced a sufficiently hard choice. This would certainly be true if morality and the law held a less demanding set of criteria for responsibility than now obtains. How could the law respond to such claims?

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99. *See infra* Part IX.

100. *See* Stephen J. Morse, *Deprivation and Desert*, *in* FROM CRIMINAL JUSTICE TO SOCIAL JUSTICE 114 (William C. Heffernan & John Kleinig eds., 2000) (considering and rejecting the various theories proposed to excuse criminal behavior solely on the basis of an unfortunate life history).

According to almost any definition, rationality and hard choice are continuum concepts.[101] Consequently, responsibility must be a matter of infinite variation. But even if rationality is easier to assess than irresistibility, it is beyond human ability to measure it precisely enough to ascribe infinite degrees of responsibility. As a result, the law adopts bright-line tests, such as legal insanity, and does not include a generic partial responsibility doctrine.[102] The law should consider a limited, generic partial excuse of "partial responsibility."[103] Although there are practical objections that might fairly be raised, the moral claim for a partial excuse is sufficiently weighty to justify bearing the potential practical costs.

As the extant, mitigating doctrines of homicide imply, some legally responsible defendants suffer from impaired rationality that warrants mitigation and triers of fact can fairly make the relatively gross culpability judgment required. The underlying theory of excuse that supports these doctrines—impaired capacity for rationality—and the doctrines themselves are perfectly generalizable to all crimes. There is no reason that juries could not reasonably make the same judgments about mitigation for other crimes that they routinely make to determine if murder should be reduced to manslaughter.

Justice would be better served if the criminal law adopted a generic partial excuse, reflected in another possible verdict, "Guilty but Partially Responsible" (GPR). Many crimes are committed when the defendant's rationality may be substantially impaired by a wide variety of factors, including the cognitive and affective changes that addiction may produce. Fairness may demand mitigation in such cases, but except within homicide or at sentencing, the criminal law has no means to do justice, and the existing means suffer from various deficiencies. A verdict such as GPR would provide a remedy. Because GPR would be a partial affirmative defense, the Constitution would permit the state to place the burden of persuasion on either the prosecution or the defense.[104]

Any formula that expressed the central mitigating notion would work as long as it addressed the underlying, normative excusing condition, used

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101. For ease of exposition, only rationality will be discussed. The argument applies equally well, however, to an internal coercion or a so-called volitional theory of excuse.

102. The major exceptions are the mitigating doctrines of homicide that reduce murder to manslaughter and sentencing practices generally.

103. *See* Stephen J. Morse, *Diminished Rationality, Diminished Responsibility*, 1 OHIO ST. J. CRIM. L. 289 (2003) (providing a full defense of a proposal for a generic partial excuse to crime and considering the practical objections).

104. *See* Patterson v. New York, 423 U.S. 197 (1977). It is important to distinguish GPR from "Guilty But Mentally Ill" (GBMI), a verdict adopted by a substantial minority of the states. GBMI reflects a jury finding that the defendant was mentally ill at the time of the crime, but that the defendant was nonetheless fully responsible for her conduct. A GBMI defendant receives no necessary reduction in sentence—indeed, in some jurisdictions capital punishment may be imposed—nor does it guarantee treatment for the defendant that otherwise would not have been available. Thus, *unlike* GPR, it is *not* a mitigating (or excusing) "defense." Indeed, it is not a defense at all. In my opinion, GBMI is a useless, confusing alternative that impermissibly allows juries to avoid finding a defendant not guilty by reason of insanity in cases in which legal insanity appears justified. GBMI is like "Guilty But Hepatitis."

common-sense terms, and was not tied to any limiting model of why a defendant suffered from the requisite disturbance. As studies of the insanity defense have shown, the words of the test are not crucial.[105] Juries just need some formulation roughly to guide their normative judgment.

Sentencing partially responsible defendants is a critical issue. Although such defendants may be less culpable, in many cases the defendant's impaired rationality may present a continuing, substantial danger. Ex-addicts often relapse and return to addictive lifestyles that may involve related, dangerous criminal conduct, especially if they return to the setting in which the addictive activity previously occurred. Unless a purely retributivist theory governs punishment—in which case, punishment must be strictly proportional only to desert—a sensible, legislatively mandated sentencing scheme must try to balance culpability and public safety interests. The legislature should set a fixed reduction in sentence for GPR. But however the reduction is characterized, applying it would be no different in principle from the penalty reduction from murder to manslaughter or from the sentence reduction for mitigation that a judge might order. Moreover, if the reduction were legislatively mandated, and assuming the continued importance of plea bargaining, its application would be more consistent than if it were left to pure judicial discretion. Again, any reasonable scheme would do.

This proposal would lump together defendants of disparately impaired rationality, and consequently, different responsibility. This may seem to be a denial of equal justice, but it results inevitably from the epistemological difficulties confronting more fine-grained assessments. To permit many degrees of partial excuse and corresponding degrees of punishment reduction would require juries and judges to make judgments with a precision beyond the capacity of both our moral theories and our ability to understand the necessary facts. Confusion and arbitrary decisions, rather than more justice, would follow from attempts at greater exactitude. If GPR were adopted, defendants in general would have the potential to obtain just mitigation that is not currently available for most. The failure to provide perfect justice in this imperfect world is not a decisive, or even a weighty objection in this instance.

In sum, GPR might be the fairest way to respond to the diminished rationality claims that some addicts and others present as a partial excuse to crime. If adopted, the law might have more flexibility in responding than under the current all-or-none approach, whereby few addicts could claim complete non-responsibility. Nothing in this scheme would prevent the law from also

105. RITA J. SIMON & DAVID E. AARONSON, THE INSANITY DEFENSE: A CRITICAL ASSESSMENT OF LAW AND POLICY IN THE POST-HINCKLEY ERA 125–27 (1988) (demonstrating on the basis of vignette methodology that the insanity defense test used made little difference in jury verdicts); HENRY J. STEADMAN ET AL., BEFORE AND AFTER HINCKLEY: EVALUATING INSANITY DEFENSE REFORM 8, 45–62 (1993) (demonstrating using California data that the test for legal insanity made little difference in operation of the insanity defense and jury verdicts).

offering voluntary treatment, and, perhaps, from imposing treatment on addicted and partially excused criminals.

B. Drug Treatment

Successful treatment of addictive states would immensely reduce the personal and social costs of addiction. But, alas, highly effective and safe treatments are not yet generally available for most substances. The new biology, including increased understanding of genetics, has not yet led to major discoveries of successful biological interventions.[106] Given the complex genetic basis for addiction, a simple gene therapy does not seem to be an imminently foreseeable possibility. Other drugs, such as methadone or naltrexone, may help some addicts kick some addictions, but no one claims that these drugs cure the underlying pathophysiology or anatomical pathology. That is, to the best of my knowledge, there is no evidence yet that these treatments reverse or ameliorate the brain changes that prolonged use allegedly produces. Better understanding of the biological mechanisms of addiction has not produced magic bullets. Even abstinence for long periods of time, with or without treatment, does not guarantee that compulsive seeking and use will not recur. If the brain disease model is right, prolonged use changes brain structure and function, but prolonged abstinence following addiction does not make the brain normal again, or at least, not normal enough. Although the brain is famously resilient, the brain disease model implies that prolonged drug use is an apparently exceptional insult that changes the brain permanently for the worse.

Despite the basic biological advances, the most successful general treatment strategies to date have been behavioral and social, including the quasi- (and not-so-quasi-) religious regimens associated with Alcoholics Anonymous and the like.[107] Indeed, self-efficacy is the crucial variable in preventing

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106. *See, e.g.*, TEXTBOOK OF SUBSTANCE ABUSE TREATMENT, *supra* note 56, at Part III, *Treatment for Specific Drugs of Abuse.* This authoritative text has chapters on the treatment of all specific drugs of abuse. Successful biological treatments are rare and virtually never are sufficient by themselves. *But see* COMM. TO IDENTIFY STRATEGIES TO RAISE THE PROFILE OF SUBSTANCE ABUSE AND ALCOHOLISM RESEARCH, INSTITUTE OF MEDICINE, DISPELLING THE MYTHS ABOUT ADDICTION: STRATEGIES TO INCREASE UNDERSTANDING AND STRENGTHEN RESEARCH 73–87(1997) (stating a more optimistic view based on recent research, but still admitting limited effectiveness and substantial knowledge gaps). Charles P. O'Brien is considerably more optimistic about the possibility of using naltrexone in a long-acting depot form to treat opioid addiction. Letter from Charles P. O'Brien, M.D., Ph.D., Department of Psychiatry, University of Pennsylvania to Stephen J. Morse (Sept. 17, 2003) (on file with the author); *see also* James W. Cornish, David Metzger, George Woody, David Wilson, A. Thomas McLellan, Barry Vandergrift & Charles P. O'Brien, *Naltrexone Pharmacotherapy for Opioid Dependent Federal Probationers*, 14 J. SUBSTANCE ABUSE TREATMENT 529 (1997) (reporting a successful naltrexone treatment program in a small and non-random sample of federal probationers); *see generally* Charles P. O'Brien, *Anticraving Medications for Relapse Prevention: A Possible New Class of Psychoactive Medications* 162 AM. J. PSYCHIATRY 1423 (2005) (reviewing anticraving treatments); Frank J. Vocci, Jane Acri & Ahmed Elkashef, *Medication Development for Addictive Disorders: The State of the Science* 162 AM. J. PSYCHIATRY 1432 (2005) (reviewing the development of pharmacotherapies for several substance abuse disorders).

107. *See, e.g.,* TEXTBOOK OF SUBSTANCE ABUSE TREATMENT, *supra* note 56, at 151–321 (detailing treatments for specific drugs); David Ball, *Genetic approaches to alcohol dependence*, 185 BRIT. J.

relapse.[108] Those committed to the primarily biological model do not deny the importance of behavioral variables and of social context and cues. Keeping the addict away from the setting in which use typically occurs is powerfully prophylactic, for example. Nonetheless, these methods too have limited efficacy.

We should be modest about treatment efficacy, but treatment can be helpful, and, reasonably presumably, increasingly effective biological and psychosocial treatment methods for addictions will become available. For example, biomedical research might develop an opioid antagonist that is safer and more easily administered than naltrexone. Should such treatments be offered voluntarily to addicts within the control of the criminal justice system (and to addicts not under such control) and may it be imposed on addicts who will not consent to treatment?

Assuming that resources to treat addicts are available without diminishing resources for other, more worthy goals, social justice plausibly requires that society try to help people who suffer from conditions that debilitate their own lives and are costly to the lives of others, especially if such people are imprisoned and thus entirely under the state's control.[109] Moreover, substances play such a large role in criminal behavior that it simply makes good sense to try to reduce the costs of drug- and addiction-related crime through treatment.

The more difficult question is whether the state may impose treatment, either forcibly or by coercive practices. The Supreme Court has held that prisoners have a liberty interest in avoiding unwanted psychotropic drug treatment, but that the state may override that interest and treat prisoners involuntarily if treatment is medically warranted and necessary to insure the safety of the inmate or others in the institution.[110] Probably few addicts in prison would qualify for involuntary treatment based on substance disorder alone,[111] but could the state offer better conditions in prison or shorter prison terms to induce addicted prisoners to enter drug treatment programs? Could prisoners give informed consent to such treatment? Would such conditions violate ethical or constitutional prohibitions because they were too coercive and would coercive programs be effective even if they were ethically and legally acceptable? Many believe that such conditions are implicitly and unacceptably coercive and that informed consent is impossible in such circumstances. Therefore, unless the state has a sufficiently strong interest to override the

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PSYCHIATRY 449, 450 (2004) ("Psychiatric genetics has yet to deliver on its early promise and it has not yielded any major advance in the management of people who are alcohol-dependent.").

108. C. Robert Cloninger, *Genetics of Substance Abuse*, in TEXTBOOK OF SUBSTANCE ABUSE TREATMENT, *supra* note 56, at 73, 78–79.

109. This point is weakly stated as only a "plausible claim," even though it is my belief, because what social justice demands is notoriously controversial. Many might deny the premise about resources or claim that prisoners have the least strong claim in our society to limited social resources. For such people, only consequential arguments might be persuasive.

110. Washington v. Harper, 494 U.S. 210 (1990).

111. Many addicts, of course, suffer from co-morbidities, and it is possible that such treatment might be permissible based on non-addiction disorders.

prisoner's liberty interest in avoiding unwanted treatment, such treatment cannot be employed.

Coercion is a notoriously fraught concept. The most common account distinguishes between offers, which are thought to increase freedom and are thus not coercive, and threats, which decrease freedom and are potentially coercive.[112] The problem is to distinguish the two, which is difficult to do except against a political and moral baseline that will itself be contestable. For example, assume that a person is lying injured and helpless by the side of the road. A physician arrives, identifies herself as a doctor, and asks if she can be of assistance. The injured person asks the doctor to help. The doctor responds that she will do so for a fee. If physicians have a duty in that society to help in such circumstances without a fee, then the response is a threat; if physicians have no such duty, then the response is an offer. Many cases cannot be so neatly distinguished, however, and whether physicians should have to offer services without a fee in such case is a controversial moral and political question. Assuming that the baseline can be justified and the case can be identified as a threat, another difficult question is how serious the threat must be to be deemed unacceptably coercive. For example, assume that everyone has a right not to be touched without consent. Suppose a malefactor says that she will touch you without your permission unless you kill an innocent bystander. The case is clearly one of threat, but the situation would be insufficiently coercive to satisfy the criteria for duress that might excuse a threatened agent who does wrong in response. The criterion of "sufficient threat," although standard, is contestable and under-determinative. Nonetheless, it can help clarify the coerciveness of drug treatment programs.

In *McKune v. Lile*, the Supreme Court was asked to determine whether the conditions accompanying a prison treatment program for sex offenders were coercive and unconstitutional.[113] The treatment program was voluntary, but it required all participants to confess without immunity to any prior uncharged sex offenses that they may have committed. Although no participant had ever been subsequently charged for an uncharged but confessed offense, it was a theoretical possibility. If a sex offender refused to participate, he was subject to much harsher prison conditions than those who did participate. The Supreme Court held that the program did not violate the prisoner's Fifth Amendment rights and was not coercive.[114] Although the Court rejected a threat/offer mode of analysis, the holding was based on the argument that the state had a right to impose the harsher conditions in the absence of a treatment program, so the situation was not coercive. Thus, it appears that the best explanation for the Court's holding is that the program was an offer, not a threat.

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112. Wertheimer offers a particularly complete account of the various legal and philosophical approaches in addition to his own theory. *See* WERTHEIMER, *supra* note 70.

113. McKune v. Lile, 536 U.S. 24 (2002).

114. *Id.*

By analogy to *McKune*, it seems that the state can to some undetermined extent use the leverage of the criminal justice system to induce an otherwise unwilling prisoner to enter a treatment program. Indeed, the acceptance of much current mental health treatment is motivated by various forms of leverage used by the state's agents.[115] And there is no clear evidence that arguably or undeniably coercive treatment is ineffective.[116] Given the costs that addicts impose on our society, there will be strong pressure to find various inducements morally and constitutionally acceptable, especially if the treatments available are efficacious at reasonable cost in reducing drug-related criminal behavior.

C. Sensible Criminalization Policy

According to the dominant legal model of the person, the criminal law operates by providing rules and consequences for violating the rules that give potential miscreants good reasons not to offend. The model assumes that the creatures to whom these reasons are addressed are generally capable of using them as premises in practical reasoning that should in most cases lead to the conclusion that the agent should not violate the law. Of course, society is delighted if other forms of social control, such as internalized conscience and informal sanctions, also tend to limit criminal conduct.

The question for the law is whether and to what degree we should criminalize drug-related offenses committed by addicts and non-addicts. No sensible person thinks that the criminal law is sufficient to reduce the level of criminalized harms to acceptable levels in a world of morally imperfect beings who inhabit a non-police state. Non-criminal justice approaches to addiction can be extremely useful, even if criminalization also can help. There is no reason to believe that our thinking about addiction must be polar, that it is only brain disease or only intentional conduct, that it is best treated only medically or psychologically or only by criminalization. Addiction-related conduct can be both a sign of brain disease and intentional action, both a proper subject for treatment and for moral judgment.

No one suggests that we should criminalize and punish the status of being an addict. Indeed, doing so would be unconstitutional.[117] Moreover, failure to criminalize recreational substance use is no guarantee of an effective social response. Two of the most addictive drugs, ethanol (alcohol) and nicotine, which cause untold personal and social harm, are entirely lawful, freely available, and relatively inexpensive. The medical model's preferred mode of response to seeking and using these lawful substances is largely unfettered by

115. John Monahan et al., *Use of Leverage to Improve Adherence to Psychiatric Treatment in the Community*, 56 PSYCHIATRIC SERVICES 37, 37 (2005).

116. *See* John Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 1198, 1199–1204 (2001) (citing evidence for efficacy of mandated outpatient treatment but querying whether legally mandated treatment is necessary to achieve this result).

117. *See* Robinson v. California, 370 U.S. 660 (1962) (holding that criminal punishment solely for the status of being addicted is cruel and unusual and thus constitutionally impermissible under the Eighth and Fourteenth Amendments).

nasty criminalization, but the problems these substances cause remain grave. When people manage to quit—as many do—it is more a response to reason and self-efficacy generally than a result of medical or psychological intervention in the addicts' brains or minds.

Few people who adopt a unitary medical model suggest that production, possession, sale, and use of currently illicit drugs should be entirely decriminalized and deregulated. Criminal justice apparently plays a necessary role concerning these drug activities.[118] Seeking and using drugs are distinguishable from production, sale, and other criminal activities related to drug use. Even if one desired on "medical grounds" to decriminalize possession for personal use and such use itself, few would argue further that we should decriminalize or deregulate production, possession for sale, sale itself, or other property and personal crimes that might be part of the drug life or necessary to support addiction. Unless the authorities have some legal tool, such as the threat of criminal sanctions or enhanced punishment, to coerce users to accept treatment, many, perhaps most, will not do so willingly. Most addicts already know the other good reasons they ought to enter treatment, but many engage in denial and other defense mechanisms that may prevent them from keeping such reasons present to their minds. Finally, given the limited success of available treatment programs, the criminal justice response may ultimately be more effective at reducing drug use than providing treatment, and indeed, may protect liberty more than a paternalistic treatment approach.[119] Indeed, some sophisticated observers believe that general decriminalization would produce catastrophic increases in addiction.[120] The important questions, of course, are what the proper role of moral evaluation and criminal justice should be and whether this role is inconsistent with sensible medical responses, such as treatment. Common sense suggests that all such approaches are not necessarily inconsistent and can be simultaneously and usefully employed.

One reform that might do much to reduce both drug-related harms and criminal justice costs would be limited decriminalization of small amounts of substances possessed solely for personal use and simple use itself, coupled with enhanced enforcement of common, further drug-related harms.[121] Consider by analogy our response to drunk driving. Adult possession and use of alcohol is

118. Powell v. Texas, 392 U.S. 514, 528–31 (1968).

119. *Id.* Writing for the plurality, Justice Marshall wrote that there might be deterrent and civil liberties virtues to using the criminal justice system to respond to the behavioral consequences of alcoholism. *Id.* We have learned a great deal about the causes and consequences of alcoholism since this 1968 opinion, but the reasoning is still applicable.

120. *See* James Q. Wilson, *What To Do About Crime*, 98 COMMENT. 25 (1994).

121. Proposing any form of decriminalization of currently illicit substances raises enormously complicated and extremely controversial issues. For the purposes of this paper, however, the full argument cannot be produced. I can only gesture superficially and conclusorily at the recommended approach. For a balanced, data-driven analysis of the costs and benefits of decriminalization, see ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, & PLACES (2001). *See also* FRANKLIN E. ZIMRING & GORDON HAWKINS, THE SEARCH FOR RATIONAL DRUG CONTROL (1992).

not criminal, but the carnage produced by intoxicated drivers is well-understood. Prohibition would surely reduce the carnage, but, as we learned during our experiment with this approach, it produces vast harms of its own. A potentially sensible approach would more strictly enforce laws against drunk driving, which is probably the most foreseeably dangerous alcohol-related behavior. Similarly, limited decriminalization of currently illicit substances would probably not have catastrophic social effects and would almost certainly avoid the many appalling costs that our complete war on illicit substances now produces. Using produces harms primarily to oneself and might be better approached medically than legally. This regime certainly would facilitate voluntary seeking of treatment by addicts and others with drug problems.

A second promising reform would be diversion from the criminal justice system of minor drug-related offenders coupled with treatment in cases in which treatment seems likely to be successful.[122] The drug courts that have been established in many states are one attempt to provide such diversion and treatment.[123] This approach is controversial for many of the reasons that involuntary treatment generally raises questions, but avoiding the necessity of costly imprisonment and inducing treatment for minor offenders engaged in drug-related criminal activities is potentially cost-effective, especially if more effective and safe treatment modalities become available.

Limited decriminalization has much to recommend it as a solution to drug-related problems. Nevertheless, in the current climate of opinion concerning controlled substances, it seems very unlikely that Congress, whose power over drug regulation is near absolute,[124] will move toward any form of decriminalization.

X

CONCLUSION

Despite the exciting, undoubted advances in the biological understanding of addiction, and despite the plausibility of considering addictions diseases, the disease model does not and cannot fully explain addiction or inform social and legal policy concerning addiction. Addiction inevitably involves human action and is therefore subject to moral evaluation. Although addiction might cause a condition warranting mitigation or excuse, primarily by compromising rationality, there is good reason to believe that most addicts are responsible for

122. Douglas Longshore, Angela Hawken, Darren Urada & M. Douglas Anglin, SAPCA Cost Analysis Report (First and Second Years), *available at* http://www.uclaisap.org/prop36/documents/SACPA_COSTANALYSIS.pdf at 21–23 (2006) (studying the costs and benefits of a legislatively-mandated diversion program that offered probation and treatment to non-violent drug offenders found that incarceration costs were substantially reduced, that there were greater cost savings for some eligible offenders than for others, and that the program could be improved).

123. *See generally* DRUG COURTS: IN THEORY AND IN PRACTICE (James L. Nolan, Jr. ed., 2002).

124. *See* Gonzales v. Raich, 125 S. Ct. 2195 (2005) (holding that Congress's Commerce Clause authority includes the power to prohibit local cultivation and use of marijuana for medical purposes that is in compliance with state law).

seeking-and-using behavior and for other immoral or criminal activity related to addiction. For those who may not be fully responsible, however, modification of the existing doctrines of mitigation and excuse would be necessary to respond fairly to the claims of diminished responsibility addicts might present. Finally, although the criminal justice system might play a useful role in responding to addiction-related action, non-criminal, non-judgmental interventions also should play a substantial role. The criminal justice system response should be limited and reformed to enhance the potential efficacy of treatment approaches.

XI

POSTSCRIPT: BECOMING AN ADDICT

Let us start with pre-addiction use. Before they reach the age of reason, some children and many early and middle adolescents have substantial experience with alcohol, nicotine, and other drugs, and a small number of them become problem users. Moreover, early experimentation with substances such as nicotine is highly predictive of later behavior that risks health. Still, the simplifying assumption will be made that virtually all people do not have their first substantial experience with potentially addicting substances until they are mid-adolescents, an age at which adolescents are in general cognitively indistinguishable from adults.[125]

By the age of reason, any competent person knows generally about the dangers of addicting substances. Most people who use potentially addicting substances do not become addicts, but between fifteen and seventeen percent do.[126] On the other hand, they may misestimate the risks of becoming addicted and especially underestimate how bad it will feel to be addicted.[127] Experience with and empathy for those already addicted is simply no substitute for the real thing. Consequently, perhaps addicts are not fully responsible for their addictions because they operate with insufficient information. This claim appears plausible and not unlike one objection to advanced directives for health care. For example, if one has never faced death or has never faced it while fully competent, how does the person know what she would really want under the circumstances? Although plausible, this claim seems too strong. There is sufficiently good information as a result of both observation and indirect sources about the perils of addiction to warrant the conclusion that those who take drugs understand the risks sufficiently to be held responsible if addiction

125. *See* Stephen J. Morse, *Immaturity and Irresponsibility*, 88 J. CRIM. L. & CRIMINOLOGY 15, 52–56 (1997) (reviewing evidence that the formal reasoning powers of middle and late adolescents are indistinguishable from those of adults, but recognizing that there may be behavioral differences involving impulsiveness and susceptibility to peer pressure).

126. Deroche-Gamonet et al., *supra* note 33, at 1014. The authors refer to this as a "small proportion" of those using, but it is hardly an insignificant risk of an injurious disorder and the number is surely higher in identifiable at-risk populations.

127. *See* ELSTER, *supra* note 51, at 185.

ensues. After all, as long as people have general normative competence, including the ability to gather relevant information, perfect information is hardly required for responsibility.

One can deny that any drug use is rational because all drug use is immoral and choosing immorality is always irrational. Claiming generically that immorality is irrational is philosophically controversial, of course, and in this specific context it suggests a highly moralistic, virtue ethics. Why, precisely, is limited experimentation immoral? Because it feels good? Does all such use degrade the moral personality? Perhaps so. But, after all, limited initial experience genuinely hooks almost no one—even if the experimental or recreational user is a member of a genetically or socially at-risk population and especially if the diagnostic brain changes almost always require repeated use.[128]

The usual response to claims that experimentation is not necessarily irrational is that the process of addiction is insidious. No single instance of use seems to cross a threshold; the process is instead stealthily additive, a slippery slope. At some point, however, the addict is hooked without realizing it. Because no initial user can predict whether and when he or she specifically will become addicted, it is always irrational to start or to continue, even if one is not yet hooked. There is truth to this response, but the insidiousness of the addiction process is well -known generally and proto-addicts are usually aware that they are developing a problem before the problem becomes a diagnosable addiction. They may, of course, be "in denial" or using other defense mechanisms, such as rationalization, to avoid insight into their own conditions, but the use of defense mechanisms, an imperfect shield at best, is not an excusing condition that morality and law will recognize when serious harms occur. Again, one need not act on perfect information to be responsible. It is difficult to resist the conclusion that most and perhaps all use prior to addiction is conduct for which the user is responsible and has some awareness of the risk of potential addiction. Consequently, it is also difficult to resist concluding that most addicts are responsible for becoming addicted.

Most addictions probably occur as a result of conscious and not-so-conscious indifference to the risk of becoming addicted, but plausibly it may be rational in some cases to choose intentionally to become an addict and to enter the addictive "life." This claim should be distinguished from the controversial arguments made by Gary Becker and others that addiction is itself rational.[129] My argument is that it can be rational to choose to become irrational, assuming, *arguendo*, that at least some addicts are irrational about their lives when they are addicted.

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128. Peter W. Kalivas & Nora D. Volkow, *The Neural Basis of Addiction: A Pathology of Motivation and Choice*, 162 AM. J. PSYCHIATRY 1403, 1405–06 (2005) (finding repeated use of addictive drugs induces structural changes in neural circuitry).

129. *See, e.g.*, Gary S. Becker, *A Theory of Rational Addiction*, *in* ACCOUNTING FOR TASTES 50 (1996).

Imagine a young person who has lived an extraordinarily deprived life and who therefore has little human capital and few prospects. It is possible that the person could acquire the life skills and education needed to beat the odds, but rational calculation would suggest that the odds are overwhelmingly against success. In such circumstances, one can easily imagine that a life of intermittent "highs" or oblivion, for example, would be preferable to a clean, straight life, despite the threat of poverty, disease, and prison. Such a life would be a limited but manageable, employing substances to help ignore or alleviate the misery of existence. Choosing such a life would be quite rational.[130]

Even if consciously risking or intentionally choosing to become an addict is not rational behavior, responsibility for conduct does not require acting for good, rational reasons. It is sufficient that the agent retain the general capacity for rationality. Until addiction occurs—and perhaps thereafter—there is little reason to believe that otherwise responsible agents do not retain this general capacity.

Finally, few people are compelled to become addicted. Peer pressure to experiment may be common in adolescence and early adulthood, but it seldom takes a form that would justify a compulsion excuse. First use is almost always intentional and in most cases rational, because virtually no one is immediately hooked or harmed. The user tries the substance to please friends, for the thrill of experimenting or being on the edge, for the pleasure or arousal the substance produces, and for a host of other reasons that do not suggest excusing irrationality. Moreover, almost no one is literally forced to become an addict by the involuntary administration of substances.[131]

In conclusion, most people who become addicts may fairly be held responsible to a substantial degree for becoming addicted. To the extent that addicts seek to use their addiction as a mitigating or excusing circumstance when they are charged with crimes related to the addiction, they become vulnerable to the claim that they have caused the condition of their own excuse and, therefore, should not be excused. This is a form of strict liability, however, and becoming an addict is distinguishable from committing crimes once one is addicted. Indeed, in some cases, such as adherence to a properly prescribed regime of addictive analgesics, becoming addicted may be entirely lawful. The better reason to hold most addicts criminally responsible most of the time—however they became addicted—is that most of the time they retain a sufficient capacity for rationality to be held responsible.[132]

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130. Although addicts may be largely responsible for becoming addicts and also responsible for much of their drug-related activity while addicted, our society should try to help change the odds for those in my not-hypothetical example.

131. Infants born to addicted mothers might be an exception, but this exceptional case does not undermine the general argument.

132. *See supra* Part VIII.B.2.