

APPROACHES TO DRUG INDUCED MENTAL IMPAIRMENT IN SPECIAL CIRCUMSTANCES CASES

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1. Clinical symptomatology and behavior

A. General principles

A wide variety of drugs are classified as psychoactive because they primarily influence the way that people think, feel and behave.

Small doses of most drugs produce highly variable and typically slight effects. Higher doses or chronic use typically produce more profound effects that are more predictable.

Drugs that are taken intravenously or smoked act very quickly (i.e., within seconds). Other routes of administration take longer for drugs to take effect. Most drug effects diminish gradually over time as the drug is excreted from the body.

Most drugs can be detected for a day or two in the blood and for three days or longer in urine. A recently developed method for detecting drugs in hair can confirm use for up to six months after last use.

Toxicological evidence of drugs in blood or urine cannot be used to determine with any degree of precision how large a dose was ingested, how long ago it was ingested, or whether the person was under the influence of the drug at a particular point in time.

Repeated use of a drug may cause tolerance to develop if the time interval between doses is shorter than the time required to excrete previous doses tolerance builds rapidly (within a few days) for most stimulants but may take up to a few weeks to develop with tranquilizers, sedatives, alcohol, and most (short-acting) opiates such as heroin.

Once tolerance is developed, a person must take a higher dose to produce the same effects that were previously experienced with lower doses. Tolerance develops at different rates for different drug effects. Thus, a person may experience or exhibit some but not all effects of a drug once they have become tolerant. For some drugs (e.g. amphetamines) the lethal dose increases as tolerance develops. Thus a person may take daily doses that would be fatal to a person who is not tolerant.

The effects of many drugs are magnified (potentiated) when taken in combination with alcohol or other sedative-hypnotic drugs. When drugs with opposing effects (e.g., alcohol and cocaine) are taken in combination, the person may appear less impaired, but neither drug's effects are canceled out.

Drug effects are often heightened in young children, the elderly, and in people with brain pathology or serious illness (including mental illness). The effects of drugs may be idiosyncratic among these groups of users.

Underlying personality characteristics and mental conditions may influence the way a person responds to drugs, particularly at low doses. The best predictor of how a person will act while under the influence of drugs is how they have acted previously under the influence of the same drugs.

B. Overview of Typical Effects

1. The ability to perceive and recall events accurately may be affected by:

Tranquilizers, sedatives, alcohol, opiates, marijuana, LSD (and other hallucinogens), PCP and some anti-psychotic or anti-depressive medications.

Cocaine and amphetamines do not greatly affect perception except in the case of users whose paranoia may lead them to perceive benign events as threatening. These drugs do not impair memory *per se*, but users' memory may be impaired by associated sleep deprivation, by other drugs used to compensate for the stimulant effects or by their typically frenetic life style.

2. The ability to formulate and execute a plan with anticipation of consequences and consideration of alternative courses of action may be impaired by:

Tranquilizers, sedatives, alcohol and some antipsychotic and antidepressive medications that affect the ability of the person to perceive clearly, to focus on relevant information, or to pay attention to more than one thing at a time.

Cocaine, amphetamines and other stimulants that cause the user to experience a rapid flight of ideas and lead them to act impulsively.

LSD (and other hallucinogens), PCP and extremely potent marijuana or hashish that may result in confused and disoriented thoughts and perceptions, sometimes including actual hallucinations or delusions.

Heroin and other opiates that may render the person unable to act on consciously held plans at the height of intoxication (shortly after use) or when they are suffering from intense withdrawal.

[N.B. All of the drugs mentioned above may also impair the ability of the user to understand and respond to Miranda warnings or make a voluntary statement. Marijuana, tranquilizers, sedatives, alcohol and opiates may also increase users' suggestibility in these situations.]

3. Drugs that increase potential for (typically unmotivated) violence include:

Cocaine, amphetamines and other stimulants that almost invariably result in a paranoid toxic psychosis when used chronically in high doses. Toxic psychosis may result from lower doses

among relatively inexperienced users but this is extremely rare. Crack or freebase cocaine may result in explosive violence ("crack rage") in occasional or chronic users without the gradual onset of paranoia that precedes violence among users of amphetamines or cocaine ingested in other forms.

PCP (phencyclidine) also produces a toxic psychosis characterized by bizarre behavior that may include violence. The psychotic state produced by PCP may persist for days or weeks after the drug is fully excreted. This differs dramatically from amphetamine or cocaine psychoses whose symptoms diminish progressively as the drug is excreted.

Alcohol may increase the potential for violence due to its disinhibiting effects on higher cortical brain functions and its effects on perception. In rare circumstances violence may result from ingestion of small to moderate amounts of alcohol among individuals who are diagnosed with Pathological Intoxication (formerly Alcohol Idiosyncratic Reaction).

Violence has also been associated with the use of some tranquilizers (e.g. Halcion and related benzodiazapines) that may also cause profound short term memory loss. The potential for both motivated and apparently unmotivated violence may be increased among users of anabolic steroids taken by athletes and body-builders.

II. Explaining Drug Use

A. Guilt phase testimony

Expert witness testimony about drugs in the guilt phase should focus on educating the jury about the effects of the relevant drugs, typical patterns of use, etc. Most juries are interested in this kind of information if it is presented clearly, without a lot of technical or scientific jargon or psycho-babble

In describing drug effects the expert should use examples and metaphors that will help the jurors to recognize situations in which they have experienced effects that are similar to those produced by drugs or in which they might be motivated to seek the effects of a drug.

The expert must establish credibility as an educator before he is asked to deal with the facts of the case. By the time the expert is asked to give an opinion about the effects of drugs on the defendant they should be able to anticipate his answer on the basis of what they have already learned. The use of demonstrative evidence to illustrate drug effects is an effective way of keeping the jurors' attention focused on the points that the expert has presented,

In cross-examination the expert should readily acknowledge that it is impossible to know exactly how the defendant was affected by drug use, that many users of the same drug do not commit crimes, that it is impossible to know the exact contents or purity of street drugs, etc. The expert should then review all of the evidence that shows the defendant's behavior was consistent with the effects of the drugs he used, leading to the conclusion that it is more reasonable to assume that the defendant was acting under the influence of the drugs than not.

Of course, there must be a viable legal theory and a showing of relevance of the testimony. The following approaches may be fruitful in this respect.

1. Diminished Intent

Penal Code ¶22(b) states specifically that "evidence of voluntary intoxication is admissible solely on the issue of whether or not the defendant actually found a required specific intent, premeditated, deliberated, or harbored malice aforethought, when a specific intent crime is charged".

Whether or not evidence of voluntary intoxication can be used to "reduce" culpability is a issue which is before the California Supreme Court as of the date of this outline. See People v. Saille 221Cal.App 3d 307 (1990, Review granted 10/11/90).

An analysis of a diminution in culpability due to mental illness can be seen in People v. Molina, 202 Cal. App. 3d 1168 (1989). This issue is, however, also currently before the California Supreme Court. See People v. Massi 221 Cal. App. 3d 558 (1990, Review granted 10/11/90).

2. Intoxication as "evidence" of Heat of Passion.

As noted below, it is common for many of our clients to "self-medicate" with licit and illicit intoxicants. This is especially so for individuals who are mentally ill or otherwise incapable of obtaining medication and treatment through "normal" channels.

Viewed from this perspective, the defendant's drug usage may be viewed as a "symptom" of his or her mental state rather than a cause. This approach may apply to a variety of fact patterns. For example, a drinking or drug binge may be the duct of a Borchers/Berry "series of events over a 'considerable period of time" which culminates in a heat of passion manslaughter. See People v. Borchers, 50 Cal. 2d 321 (1950) People v. Berry, 18 Cal. 3d 509 (1976).

Don't forget the power of tailored jury instructions to establishing this kind of defense. See People v. Thompkins 195 Cal. App. 3d 247 (1987).

3. Unconsciousness caused by voluntary intoxication.

Don't forget involuntary manslaughter. See People v. Graham, 71 Cal.2d 303; Caljic 8.47.

B. Penalty phase tactics.

Under Penal Code ¶190.3, several "factors" permit introduction of evidence relating to the defendant's mental state. These include "d" (extreme mental or emotional disturbance), "h" (capacity to appreciate criminality or conform conduct impaired as a result of mental disease or defect on the effects of intoxication) and the ubiquitous factor "k"

An additional consideration is evidence to support a "lingering" or "residual" doubt about intent to kill. This may present an opportunity, at least in part, to ameliorate the loss of Carlos and the prosecution's arguments under Tison/Anderson. There is some support for this approach in People v. Thompson, 45 Cal. 3d 86 at pages 134, 135. (1988).

Perhaps the biggest hurdle to overcome in presenting evidence concerning the defendant's mental state relates to "translation" of this evidence to the fact finder. It is one thing to present evidence of mental state, it is quite another to convince him or her that it is worthy of saving your client's life, Several approaches to testimony are discussed below.

In every case of voluntary intoxication, the D.A. will argue that the defendant brought the situation on him or herself. Defusing this ploy requires a "translation" of the defendant's mental state into something to which jurors can relate.

- 1.) Intoxicant use and abuse, legal and illegal, is a social common denominator in our culture. This and other forms of compulsive behavior have been personally experienced by almost everyone.
- 2.) Almost everyone has had experiences of very abnormal thoughts or behavior, no matter how "normal" we may be. For example, most of us have had isolated, but genuinely paranoid thoughts or feelings.

C. Penalty phase testimony

Jurors are not likely to be sympathetic to a defendant who wantonly uses drugs to get high. They will be more sympathetic if one or more of the following themes can be developed through expert witness testimony.

I. The defendant was conditioned to use drugs through frequent medication from early childhood.

This might include defendants whose use of cocaine or amphetamines can be traced to the prescribed use of Ritalin for treatment of childhood hyperactivity or attention disorder, or those whose adult use of heroin follows their use of medication prescribed to relieve chronic pain from an early traumatic accident or congenital deformity.

2. The defendant used drugs as self-medication for an undiagnosed or otherwise untreated medical condition.

This might include defendants who discover that stimulants help them to overcome a chronic lack of energy that can be traced to an underlying medical condition, or those who turn to sedative-hypnotic drugs to overcome chronic anxiety states that may be constitutional.

3. The defendant used drug as self medication to overcome pain or to copewith the stresses associated with severe physical, sexual or emotional abuse in childhood.

This includes defendants whose normal psychological development was impaired by childhood abuse and who turn to drugs to compensate for deficiencies in their ability to cope with stress. It can be argued that this use of drugs is the same as the use of antibiotics to deal with an infection; it is appropriate to use drugs when our own natural resources are not sufficient to overcome a threat to our well-being.

4. The defendant began using drugs or dramatically increased his use of drugs during a period of emotional vulnerability following a traumatic loss or disappointment.

This includes defendants who fall prey to the seductive influence of drugs when they are in a state of shock following a catastrophic loss (e.g., death of a loved one, separation, divorce) or disappointment (e.g., loss of job, failure to achieve something important). People in this state are vulnerable to seductions of many kinds, including cult initiation, This is a natural reaction, but in this case it led to tragic consequences because the defendant turned to a drug that also causes adverse effects.

5. The defendant has an extensive history of drug abuse that has never been properly appreciated or treated.

This is a last-ditch category that focuses on the failure of parents, relatives, teachers, counselors, parole agencies and institutional staff to recognize the severity of the defendant's drug abuse problem and their corresponding failure to insure that he receive adequate treatment,

D. Other significant issues pertaining to drug induced mental impairment.

1. Jury selection

Jury selection is critical, especially with respect to the "translation" of mental impairment issues. Jury questioning (especially questionnaires) can identify those jurors who are biased against intoxicants (abolitionists and the like). They can also identify those who might have personal experience in abusive substance use.

2. Kelly-Frye problems.

Unusual testing procedures and unusual disciplines may produce problems with respect to qualifying experts. Chemically induced abnormality may be illustrated with new procedures such as BEAM tests. Mental state "translation" problems may be addressed by unusual experts such as sociologists or anthropologists. Beware Kelly-Frye.

It is important to distinguish between "unaccepted" testing procedures and unusual or new applications of old testing procedures. See People v, Stoll 49 Cal. 3d 1136 (1989).

3. Insanity.

Generally, a self induced toxic psychosis will not support an insanity defense, if the effects disappear after the intoxication wears off. (see People v. Uriarte 223 Cal.App. 3d 192 (1990)). However, even the transitory effects of post intoxication drug abuse will support a finding of insanity if the effects were "settled". This illusive principle is established in People v. Kell, 10 Cal. 3d 565 (1973) and Caljic 4.02. Kelly is good law and we should use it.

4. Incompetence.

Voluntary ingestion of intoxicants rarely presents an incompetency problem under penal code 1367 because the effects of the intoxicant have worn off by the time of court proceedings. However, it is common for the defendant to be unable to remember all or parts of his or her involvement. Unfortunately, this "amnesia" as to the events will not support a theory that he or she is incompetent because of an inability to participate in the trial or assist counsel. See People v. Amador 200 Cal. App.3d 1449 (1988).

One undecided issue is the application of penal code section 1367 to the Kelly style temporary post intoxication effects of drug usage.