CRIMINAL LAW x ADDICTION*

DAWINDER S. SIDHU**

When an individual with an addiction commits an unlawful act that is symptomatic of the disorder, is the act involuntary and therefore beyond the reach of criminal law? The federal circuit courts are divided on this question. The majority view posits that an individual may be held criminally responsible for all unlawful acts, regardless of whether the acts are symptomatic of the disease of addiction. The en banc Fourth Circuit recently broke from these circuits, suggesting instead that an act that is symptomatic of the disease of addiction is involuntary and cannot be punished.

Both models are flawed. The first approach (the binary status-conduct distinction) asks only whether the individual committed an identifiable act. But this approach ignores the conditions under which the defendant drank or used and withdraws from the defendant the opportunity to make a showing of involuntariness based on their specific circumstances. For its part, the second approach (the categorical-involuntary model) accepts conclusory representations that the disease of addiction negates choice, without probing to any degree whether these representations are supported by any facts.

Therefore, a third model is necessary.

This Article proposes that new paradigm. It argues that courts should engage in meaningful individualized inquiries as to the voluntary or involuntary nature of the acts in question. Drawing on medical information, formal treatment programs, twelve-step fellowship programs, and the related disability context,

** The author thanks Rachel Barkow, Douglas Berman, Erwin Chemerinsky, Erin Collins, Joshua Dressler, faculty at the Center for Studies of Addiction at the University of Pennsylvania Perelman School of Medicine, and members of the criminal defense bar for helpful comments and conversations; Kelsey Robinson and Mackenzie Wigal for excellent research assistance; and the staff of the *North Carolina Law Review*, especially Nicholas Young, for improving the quality and readability of this piece. The author discloses that he is in long-term recovery and founded an outpatient addiction facility. This disclosure is offered for two reasons. First, these personal and professional experiences naturally and necessarily shape and help form the lens through which the author views the difficult legal issues addressed herein. Second, because of these experiences, the issues are not abstract matters of theory, doctrine, or policy but rather are addressed with great sensitivity to and appreciation for the real people who possess and struggle with this disease. The author emphasizes that he is writing this Article in his individual capacity and not in any effort to speak on behalf of any others, especially those in the recovery community.

this Article defines that fact-specific process, guiding courts and practitioners as to what such an individualized showing would entail. This prudent, case-by-case approach would best respect the unique circumstances of the individual facing criminal sanction as well as our fluid, evolving understanding of addiction itself.

INTRODUCTION

Criminal law may be likened to the outer limits of acceptable behavior in American society. Only when an individual crosses the line and does so voluntarily may the individual be subject to criminal punishment.[1] As stated by the prominent jurist E. Barrett Prettyman, a "basic" axiom of criminal law is that if a person "is not a free agent, or not making a choice, or . . . not acting freely," that person "is outside the postulate of the law of punishment."[2]

This Article addresses the application of this foundational principle to addiction.[3] It specifically explores whether an act that is symptomatic of the

1. *See* WAYNE R. LAFAVE, CRIMINAL LAW 206 (3d ed. 2000) ("A bodily movement, to qualify as an act forming the basis of criminal liability, must be voluntary.").

2. Carter v. United States, 252 F.2d 608, 616 (D.C. Cir. 1957).

3. "Addiction" generally refers to the chronic use of drugs or alcohol notwithstanding the adverse consequences of such use. *See Substance Abuse and Addiction Information*, UNIV. TENN.

disease of addiction may be deemed compelled by the disease and therefore involuntary for purposes of criminal law. Consider an individual who is addicted to heroin during the opioid crisis.[4] Assume further that this person has overdosed from heroin use and been revived by emergency responders multiple times.[5] Can it be a crime for this person to be a known or habitual user of heroin? Can it be a crime for this person to use heroin? What if the person used heroin to avoid acute withdrawal symptoms, including anxiety, vomiting, and loss of bowel control?[6]

The federal circuit courts are divided on these questions. The primary reason for the split is that the courts diverge as to the proper interpretation of two Supreme Court opinions from the 1960s—the last time the Court squarely addressed the intersection of criminal law and addiction.[7] A majority of circuits posit that an individual with an addiction can be held criminally responsible for their acts, regardless of whether the relevant acts are symptomatic of an addiction.[8] Under this status-conduct formulation, the individual may be held criminally liable in the second (an individual who uses heroin) and third (an individual who uses to avert severe withdrawal symptoms) scenarios provided above because they both contain an actus reus. The en banc Fourth Circuit recently broke from its sister circuits, suggesting instead that actions symptomatic of the disease of addiction are nonvolitional and therefore beyond the reach of the criminal law.[9] Under this rule, the individual with an addiction cannot be held criminally responsible in any of the aforementioned situations because any actions are involuntary on account of the disease of addiction. The difference in principle thus produces different legal outcomes.

HEALTH SCI. CTR., https://uthsc.edu/comc/well-being/substance-abuse-information-chattanooga.php [https://perma.cc/CXC7-XTHV] (last updated Sept. 28, 2020) ("Addiction is a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence. People with addiction . . . keep using alcohol or a drug even when they know it will cause problems."). While "alcohol use disorder" and "substance use disorder" are the preferred terms in clinical settings, *see infra* Section I.C, this Article elects to use the lay terminology of "addiction."

4. For an excellent overview of the development of the opioid epidemic in the United States, see generally BETH MACY, DOPESICK: DEALERS, DOCTORS, AND THE DRUG COMPANY THAT ADDICTED AMERICA (2018).

5. This is not uncommon. *See, e.g.*, Kate Ryan, *Montgomery Co. Sees Slight Drop in Opioid Overdose Deaths*, WTOP (Oct. 18, 2019, 3:50 PM), http://wtop.com/montgomery-county/2019/10/montgomery-county-sees-slight-drop-in-opioid-overdose-deaths [https://perma.cc/5LQT-ETVW] (sharing the story of a woman, now in recovery, who overdosed eighteen times).

6. Jeffery Juergens, *Heroin Withdrawal and Detox*, ADDICTION CTR. (Dec. 2, 2020), https://www.addictioncenter.com/drugs/heroin/withdrawal-detox/ [https://perma.cc/QD4U-SUET].

7. *See infra* Section II.B.

8. *See infra* Section II.C.1.

9. *See infra* Section II.C.2.

Both models are flawed. The first approach—which focuses only on whether the criminal punishment follows some actus reus[10]—prevents the individual with an addiction to alcohol or drugs[11] from being able to make an evidentiary showing that their specific circumstances precluded their ability to comply with the law.[12] At the same time, the second approach—which asks only whether the defendant possesses an addiction—ignores the general capacity of the individual with an addiction to exercise choice and therefore absolves the individual of criminal responsibility without probing whether individual circumstances prevented the individual from addressing their addiction and its adverse manifestations.[13]

A new model is needed. This Article argues that courts should engage in meaningful individualized inquiries as to the voluntary or involuntary nature of the acts in question.[14] This Article draws on medical information, formal treatment programs, twelve-step fellowship programs, and the related disability context to define this process and to guide judges and practitioners as to what such an individualized showing would entail. This prudent, case-by-case approach would best respect the unique circumstances of the individual facing criminal sanction as well as our evolving understanding of addiction itself.

This Article begins by establishing a historical and conceptual baseline for the discussion of the three competing models. Part I of this Article specifically offers an overview of the early understanding of addiction in the United States; explains the prevailing disease model of addiction; and addresses how addiction is currently treated, covering both formal rehabilitation programs and more peer-led twelve-step fellowship programs. Building on this foundation, Part II turns to law, noting how issues implicating addiction have arisen in the criminal law concepts of intoxication and insanity. Part II then summarizes *Robinson v. California*[15] and *Powell v.*

10. *See* United States v. Apfelbaum, 445 U.S. 115, 131 (1980) ("In the criminal law, both a culpable *mens rea* and a criminal *actus reus* are generally required for an offense to occur."). The former corresponds with "an evil-meaning mind" and the latter with "an evil-doing hand." Morissette v. United States, 342 U.S. 246, 251 (1952).

11. This Article uses the term "individual with alcohol or drug disease" and variations thereof. With the exception of quotes from court opinions and others, this Article avoids "addict" and variations thereof, in consideration of guidance on appropriate terminology in the addiction context. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., SUBSTANCE USE DISORDERS: A GUIDE TO THE USE OF LANGUAGE 12 (2004) [hereinafter SAMHSA], http://www.naabt.org/documents/Languageofaddictionmedicine.pdf [https://perma.cc/E394-GGFY]. This Article also focuses on the possible criminal liability of an individual with alcohol or substance use disorder. It does not address other forms of addiction.

12. *See infra* Section III.A.

13. *See infra* Section III.B.

14. *See infra* Section III.C.

15. 370 U.S. 660 (1962).

Texas[16]—the Supreme Court's last two major pronouncements on criminal law and addiction—and identifies the two interpretive camps that have emerged from these twin opinions. Part III argues that these two approaches are contrary to scientific information on addiction, contrary to treatment models, and even contrary to the comparable legal regime governing disability. This Article then makes the case for the third, evidentiary model as the most clinically and legally defensible means by which to analyze when the disease of addiction renders an act involuntary for purposes of criminal law. Part IV concludes.

Courts, commentators, litigants, and the public have struggled to identify the proper relationship between criminal law and addiction, particularly because the subject of addiction implicates complex and controversial considerations of medicine, morality, and social attitudes.[17] Notwithstanding the difficulties inherent in this area of criminal law, more definitive guidance for courts and others is critically necessary. The Supreme Court last addressed criminal law and addiction in the 1960s.[18] In 2019, an en banc Fourth Circuit split 8–7 on the meaning and applicability of those cases.[19] The fair administration of criminal justice is undermined by such substantive uncertainty and disparity. This Article aims to provide that much-needed conceptual clarity, translating medical and treatment information into optimal legal rules, thereby giving courts and litigants a more durable and sound process by which to adjudicate questions of criminal responsibility and addiction.[20] As the nation remains in the throes of an opioid crisis, determining whether and when individuals with an addiction to drugs or

16. 392 U.S. 514 (1968).

17. For example, consider a recent exchange, which played out in the pages of *The Baltimore Sun*, on whether and when the criminal justice system should intersect with addiction. *See* George Hammerbacher, *Should Police Look the Other Way When Addicts Steal?*, BALT. SUN (Nov. 24, 2020), https://www.baltimoresun.com/opinion/readers-respond/bs-ed-rr-drug-decriminalization-letter-20201124-uvl7sw4dkzcc3jgvoek5lribme-story.html [https://perma.cc/8J4P-DWHS (dark archive)]; Dale Klatzker, Opinion, *Gaudenzia: Partnering with Justice System Necessary for Effective Addiction Treatment*, BALT. SUN (Nov. 6, 2020), https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-1109-gaudenzia-treatment-20201106-heurk4unynh5db7mgoli76od7i-story.html [https://perma.cc/Q2M9-FZW3 (dark archive)]; Brendan Saloner, Letter to the Editor, *Drug Treatment Works Better Without Police Involvement*, BALT. SUN (Nov. 18, 2020), https://www.baltimoresun.com/opinion/readers-respond/bs-ed-rr-drug-treatment-police-letter-20201118-6ffvyhfjqveqziibqusznwl6ka-story.html [https://perma.cc/MVR2-F7VT (dark archive)].

18. *See Robinson*, 370 U.S. at 660; *Powell*, 392 U.S. at 514–15.

19. Manning v. Caldwell, 930 F.3d 264, 268 (4th Cir. 2019) (en banc).

20. This Article addresses only the threshold question of whether criminal liability is appropriate for conduct symptomatic of addiction and not the second-order issue of the form and length of the resulting punishment. As a preliminary matter, however, punishment that serves rehabilitative purpose would be the most sensible and defensible to help the individual better address the manifestations of their disease, reduce the prospects for recidivism, and yet ensure that the individual meets some consequences for stepping over the lines of the law.

alcohol may face criminal penalties (and associated collateral consequences) for symptomatic conduct cannot wait and matters in real terms.

I. WHAT IS ADDICTION: HISTORY, DIAGNOSIS, AND TREATMENT

This part addresses the basics of addiction. First, it describes how addiction has been conceptualized historically, tracing attempts to understand addiction in early America through Prohibition. Second, it discusses the current, prevailing disease model of addiction, summarizing how alcohol and drugs affect the brain and noting criticisms of the disease model. Third, it explores how addiction is treated, sketching formal clinical options and peer-based twelve-step fellowship programs.

A. *Historical Understanding*

Intoxicants occupy a complicated space in American history and society. In general, that history suggests generally permissive attitudes towards heavy consumption of alcohol, accompanied by attempts to address excessive drinking and its harms. In colonial and early America, "[m]ost of the population, from youth to old age, consumed [alcohol], often at every meal, from breakfast through supper."[21] In 1790, "an average American over fifteen years old drank just under six gallons of absolute alcohol each year."[22] This amount rose to over seven gallons in 1810.[23] The trend continued. "[I]n the 1820's the typical American man was putting away half a pint of [corn whiskey] every day."[24] "[D]uring the first decades of the 19th century . . . Americans [went] on a collective bender that confronted the young republic with its first major public-health crisis . . . ."[25]

Noteworthy figures in the founding generation shared the general public's taste for alcohol. Chief Justice John Marshall, for example, purchased two 126-gallon casks of madeira per year.[26] Benjamin Franklin rather famously

21. Lisa Lucas, Comment, *A New Approach to the Wine Wars: Reconciling the Twenty-First Amendment with the Commerce Clause*, 52 UCLA L. REV. 899, 914 (2005) (quoting Richard F. Hamm, *Short Euphorias Followed by Long Hangovers: Unintended Consequences of the Eighteenth and Twenty-first Amendments*, *in* UNINTENDED CONSEQUENCES OF CONSTITUTIONAL AMENDMENT 164, 166 (David E. Kyvig ed., 2000)).

22. MARK EDWARD LENDER & JAMES KIRBY MARTIN, DRINKING IN AMERICA: A HISTORY 14 (1982).

23. *Id.* at 46.

24. Lucas, *supra* note 21, at 915 (quoting Michael Pollan, *The (Agri)Cultural Contradictions of Obesity*, N.Y. TIMES MAG., Oct. 12, 2003, at 41, 42).

25. *Id.*

26. Jean Edward Smith, *Sallie E. Marshall Hardy's 'John Marshall'*, 3 GREEN BAG 2D 309, 310 (2000). Other Justices are known to have enjoyed alcohol. Justice Thurgood Marshall, for example, drank bourbon. *See* Elena Kagan, *For Justice Marshall*, 71 TEX. L. REV. 1125, 1126–27 (1993). Chief Justice Rehnquist's favorite lunch apparently consisted of a cheeseburger and beer. *See* Michael Q. Eagan, *Chief Justice Rehnquist: Soft Shoes Below the Bench*, L.A. TIMES (June 22, 1986), https://

remarked that wine was "proof that God loves us."[27] John Adams drank hard cider before breakfast.[28] To be fair, some framers voiced concerns related to alcohol as well. James Madison claimed that liquor was "inconsistent with the purity of moral and republican principles."[29] Adams became "so concerned about the level of drunkenness that he proposed limiting the number of taverns . . . ." [30] Even Franklin concurred, calling taverns a "[p]est to Society."[31]

The English, the colonies, and then the states prohibited drunkenness, showing little regard for those who overindulged.[32] The English effort to regulate intoxicating substances stretches back to at least 1606, in the form of a statute that condemned "the loathsom and odious sin of drunkenness," "the root and foundation of many other enormous sins, as bloodshed, stabbing,

www.latimes.com/archives/la-xpm-1986-06-22-op-20810-story.html [https://perma.cc/S3A6-8Y8Y (dark archive)]. Justice Brett Kavanaugh has professed his love of beer. *See* Frank Bruni, Opinion, *Brett Kavanaugh Loves His Beer*, N.Y. TIMES (Sept. 29, 2018), https://www.nytimes.com/2018/09/29/opinion/brett-kavanaugh-beer-politics.html [https://perma.cc/ZPJ3-M3BM (dark archive)]. Justices' relationships with alcohol are not all positive. Justice Thurgood Marshall's father was an alcoholic, David J. Garrow, *The Symbolic Justice*, WASH. MONTHLY, Nov. 1998, at 42, 42 (book review), as was Justice Sotomayor's father, SONIA SOTOMAYOR, MY BELOVED WORLD 25 (2013). Justice Clarence Thomas recounts his own heavy drinking. *See* Jan Crawford Greenburg, *Clarence Thomas: A Silent Justice Speaks Out*, ABC NEWS (Oct. 1, 2007, 4:29 PM), https://abcnews.go.com/TheLaw/story?id=3664638 [https://perma.cc/E7NM-5G2P]. Justice William O. Douglas was known to be an alcoholic. Then-Judge Posner blasted Justice Douglas for his "heavy drinking" and other attributes, calling him "one of the most unwholesome figures in modern American political history . . . ." Richard A. Posner, *The Anti-Hero*, NEW REPUBLIC, Feb. 24, 2003, 27, 27 (book review). Though not a justice, U.S. District Judge John Pickering was impeached and removed from office in large part because of his drinking. *See* NANCY MAVEETY, GLASS AND GAVEL: THE U.S. SUPREME COURT AND ALCOHOL 12 (2019).

27. Tenn. Wine & Spirits Retailers Ass'n v. Thomas, 139 S. Ct. 2449, 2476–77 (2019) (Gorsuch, J., dissenting).

28. DAVID MCCULLOUGH, JOHN ADAMS 36 (2001).

29. LENDER & MARTIN, *supra* note 22, at 39; *see also* Letter from George Washington to Thomas Green (Mar. 31, 1789), *in From George Washington to Thomas Green, 31 March 1789*, NAT'L ARCHIVES: FOUNDERS ONLINE, https://founders.archives.gov/documents/Washington/05-01-02-0364 [https://perma.cc/SK68-RB99] (writing that "drink . . . is the source of all evil—and the ruin of half the workmen in this Country").

30. Harry Gene Levine, *The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America*, 2 J. SUBSTANCE ABUSE TREATMENT 43, 44 (1985).

31. *Id.* at 145. For an informative discussion of widespread alcohol use during the founding period, see Alan Taylor, *Alcohol Use in the Early American Republic*, C-SPAN (Mar. 5, 2014), https://www.c-span.org/video/?317982-1/lecture-early-us-alcohol-consumption [https://perma.cc/47JY-5NZ3].

32. The distaste of alcohol extends back millennia, prior to the existence of the Anglo-American legal tradition. *See* Loretto Winery Ltd. v. Gazzara, 601 F. Supp. 850, 853 n.5 (S.D.N.Y. 1985) ("Who hath woe? who hath sorrow? who hath contentions? who hath babbling? who hath wounds without cause? who hath redness of eyes? They that tarry long at the wine; they that go to seek mixed wine." (quoting *Proverbs* 23:29–30)).

murder, swearing, fornication, adultery, and such like."[33] Similarly, New York laws of 1665–1675 forbade those "overtaken with Drink."[34] Comparable statutes were enacted in early America.[35] Punishments in this era for violations of such laws included whippings and the stocks.[36]

Such statutes reflected the prevailing moral opprobrium attached to individuals deemed to be "drunkards." The same statutes prohibiting excessive drinking also applied to "vagrant persons," lying, gambling, prostitution, witchcraft, cock-fighting, and profane cursing.[37] Fueling the negative social perception of the "drunkard" was the general sense that excessive drinking was a product of an individual's choice and thus the proper subject of social judgment and legal punishment. In 1754, for example, Jonathan Edwards wrote that the desire of the "drunkard" to drink cannot be attributed to anything other than "choice" or "election."[38] Edwards rejected the argument that the "drunkard" is unable to stop drinking: "It cannot be truly said . . . that a drunkard, let his appetite be never so strong, cannot keep the cup from his mouth."[39]

One chief exception to the general view that drunkenness represented a choice appears in the writings of Dr. Benjamin Rush, who served as Surgeon General of the Continental Army, signed the Declaration of Independence, and worked as a physician and professor.[40] Rush appreciated the powerful hold that addiction had on the individual. He recounted the words of an individual addicted to alcohol: "Were a keg of rum in one corner of a room, and were a cannon constantly discharging balls between me and it, I could not refrain from passing before that cannon, in order to get at the rum."[41] Rush claimed that, while "[t]he use of strong drink is at first the effect of free

33. Jayesh M. Rathod, *Distilling Americans: The Legacy of Prohibition on U.S. Immigration Law*, 51 HOUS. L. REV. 781, 792 n.55 (2014) (citing (1606) 4 Jacob's Ch Rep. I, c. 5 (Eng.) (third alteration in original)).

34. EARLIEST PRINTED LAWS OF NEW YORK, 1665–1693, at 133 (John D. Cushing ed., 1978).

35. FIRST LAWS OF THE STATE OF CONNECTICUT 23 (John D. Cushing ed., 1982) (authorizing arrest for those "guilty of Drunkenness"); COLONIAL LAWS OF MASSACHUSETTS 139 (1889) (permitting punishment of those "overtaken with drink"); DIGEST OF THE LAWS OF NEW JERSEY, 1709–1861, at 896 (Lucius Q.C. Elmer ed., 1861) (labeling "common drunkards" as "disorderly persons"); 3 LAWS OF THE COMMONWEALTH OF PENNSYLVANIA, 1700–1810, at 178 (1810) (making any person who engages in "excessive drinking of spiritous, vinous, or other strong liquors" subject to conviction).

36. Levine, *supra* note 30, at 44.

37. *See, e.g.*, FIRST LAWS OF THE STATE OF CONNECTICUT, *supra* note 35, at 23; COLONIAL LAWS OF MASSACHUSETTS, *supra* note 35, at 139; DIGEST OF THE LAWS OF NEW JERSEY, *supra* note 35, at 896; LAWS OF THE COMMONWEALTH OF PENNSYLVANIA, *supra* note 35, at 177–83.

38. JOHNATHAN EDWARDS, FREEDOM OF THE WILL 10, 231 (1754).

39. *Id.* at 37.

40. *Dr. Benjamin Rush: Father of American Psychiatry*, PENN MED., https://www.uphs.upenn.edu/paharc/timeline/1751/tline7.html [https://perma.cc/YF7E-WVT6].

41. BENJAMIN RUSH, MEDICAL INQUIRIES AND OBSERVATIONS, UPON THE DISEASE OF THE MIND 266 (1812).

agency," habitual drinking "takes place from necessity."[42] At this point, drinking is no longer an act of free will but rather the product of a "disease of the will," he concluded.[43]

Rush's writings, prescient from today's vantage point, occupied a minority position during his time. The dominant approach was grounded in concerns about the immorality of drunkenness and the social harms stemming from it.[44] A series of cases from the late nineteenth century reflect the majority view. In them, the Supreme Court repeatedly stressed that states could regulate alcohol under their police powers, as alcohol implicates governmental interests in health, safety, and morality.[45] Echoing the 1606 English statute, the Supreme Court in 1887 confessed that "we cannot shut out of view the fact, within the knowledge of all, that the public health, the public morals, and the public safety, may be endangered by the general use of intoxicating drinks . . . ."[46] "[N]or [can we ignore] the fact, established by statistics accessible to every one, that the idleness, disorder, pauperism, and crime existing in the country are, in some degree at least, traceable to this evil," the Court continued.[47]

Abraham Lincoln himself entered the fray. Addressing temperance advocates, he stated, "[T]he practice of drinking [intoxicating beverages] is just as old as the world itself . . . ."[48] "When all such of us, as have now reached the years of maturity, . . . we found intoxicating liquor, recognized by everybody, used by every body, and repudiated by nobody," he added.[49] It is true, Lincoln acknowledged, that "many were greatly injured by it."[50] But, he said, "none seemed to think the injury arose from the *use* of a *bad thing*, but from the *abuse* of a *very good thing*."[51] He shared the hope that there should be no more "drunkards" in society, suggesting that the way to achieve this

42. *Id.*

43. *Id.* at 269.

44. For arguments on how this regulatory power was applied to suppress slaves, see Frederick Douglass, Address Delivered in Glasgow, Scotland, on Intemperance Viewed in Connection with Slavery (Feb. 18, 1846), *in* Yale Macmillan Ctr., *Intemperance Viewed in Connection with Slavery*, YALE U., https://glc.yale.edu/intemperance-viewed-connection-slavery [https://perma.cc/YB6C-MANY]. For arguments on how this regulatory power was applied to minority and immigrant communities generally, see Rathod, *supra* note 33, at 798–814.

45. *See, e.g.*, Foster v. Kansas, 112 U.S. 201, 206 (1884); Beer Co. v. Massachusetts, 97 U.S. 25, 32 (1877); Bartemeyer v. Iowa, 85 U.S. (18 Wall.) 129, 133 (1873); Thurlow v. Massachusetts, 46 U.S. (5 How.) 504, 532–33 (1847).

46. Mugler v. Kansas, 123 U.S. 623, 662 (1887).

47. *Id.*

48. Abraham Lincoln, Temperance Address (Feb. 22, 1842), *in Temperance Address*, ABRAHAM LINCOLN ONLINE, http://www.abrahamlincolnonline.org/lincoln/speeches/temperance.htm [https://perma.cc/TGE4-MYZS].

49. *Id.*

50. *Id.*

51. *Id.*

outcome is "entreaty and persuasion," not "the thundering tones of anathema and denunciation."[52]

Notwithstanding Lincoln's protestations, the temperance movement gained momentum, reaching a tipping point with Prohibition. As Justice Stevens wrote, "[T]he moral condemnation of the use of alcohol as a beverage represented . . . the views of a sufficiently large majority of the population to warrant the rare exercise of the power to amend the Constitution on two occasions."[53] First, the Eighteenth Amendment, ratified in 1919, prohibited the "manufacture, sale, or transportation of intoxicating liquors."[54] Prohibition failed due to states ceding enforcement of the amendment to federal authorities, the inability of federal authorities to effectuate meaningful enforcement, and the sense that the amendment itself lacked legitimacy.[55] Second, the Twenty-First Amendment, ratified in 1933, repealed the federal prohibition against transacting alcohol in commerce and yet also left open the opportunity for the states to enact their own prohibitions.[56]

America's historical experience with narcotics—opioids derived naturally or synthetically from poppy plants—is complicated as well. Narcotics were used for medical and other legitimate purposes. In 1804, after Aaron Burr shot Alexander Hamilton, for example, doctors gave Hamilton an opium-based tincture to alleviate his pain.[57] In 1810, Friedrich Sertürner discovered morphine, a substance ten times more powerful than opium that Sertürner acknowledged had addictive qualities.[58] During the Civil War, however, doctors gave ailing soldiers morphine as a painkiller and sedative, ignoring Sertürner's warnings and erroneously believing that addiction could be avoided if the morphine was injected using hypodermic needles.[59] A hundred thousand veterans of the war developed dependence on drugs or alcohol, which was referred to as "army disease" or "soldier's disease."[60] In 1874, a chemist researching nonaddictive alternatives to morphine discovered heroin.[61] Twice as powerful as morphine, heroin's medical benefits (for example, to suppress a cough, treat a cold, or act as a sedative) were promoted

52. *Id.*

53. Granholm v. Heald, 544 U.S. 460, 494–95 (2005) (Stevens, J., dissenting).

54. U.S. CONST. amend. XVIII, § 1, *repealed by* U.S. CONST. amend. XXI, § 1.

55. *See* Robert Post, *Federalism, Positive Law, and the Emergence of the American Administrative State: Prohibition in the Taft Court Era*, 48 WM. & MARY L. REV. 1, 68–69 (2006).

56. U.S. CONST. amend. XXI, § 1; *see also* Br. for Illinois, et al. at 5, Tenn. Wine & Spirits Retailers Ass'n v. Blair, 139 S. Ct. 783 (2018) (No. 18-96), 2018 WL 6168781, at *5 (describing the two primary regulatory models followed by states in the aftermath of Prohibition).

57. MACY, *supra* note 4, at 21.

58. *Id.* at 21–22.

59. *Id.* at 22.

60. *Id.*; Charles G. Hoff, Jr., *Drug Abuse*, 51 MIL. L. REV. 147, 162 (1971).

61. MACY, *supra* note 4, at 23.

and its addictive potential was downplayed.[62] By 1914, consistent with the temperance movement's crackdown on alcohol, heroin and other narcotics were prohibited.[63] Social judgments accompanied the legislative responses, with individuals addicted to drugs branded as "junkies" or worse.[64]

Following the end of Prohibition, however, alcohol and drugs proceeded along different legal tracks. The consumption of alcohol itself has been largely untouched, with the main exception being the requirement that anyone purchasing or consuming alcohol be of a minimum age.[65] That aside, the regulation of alcohol has focused primarily on ancillary or secondary issues, such as driving while under the influence of alcohol or being disorderly in public while intoxicated. By contrast, while some drugs, such as LSD, continued to be permitted for a brief period due to supposed medical or psychiatric benefits, the consumption of narcotics in any amount became strictly prohibited.[66] Such prohibitions began in earnest with the Uniform Narcotic Drug Act of 1932[67] and were heightened with the Controlled Substances Act of 1970,[68] which remains in effect today and reflects the negative social perceptions and stringent regulatory treatment of drugs in the modern era. The Controlled Substances Act categorizes substances by tiers, according to their effects upon the person and their potential for abuse.[69]

Rising concerns about drug use and associated violence in the 1980s contributed to the current, "tough" model of criminal justice. Following the tragic death of budding basketball star Len Bias from acute cocaine intoxication and the resulting national public outcry,[70] Congress rushed to enact the Anti-Drug Abuse Act of 1986.[71] This statute set forth severe mandatory minimum penalties for drug offenses and established the infamous one-hundred-to-one ratio of the quantity needed to trigger mandatory

62. *Id.* at 23–24.

63. *Id.* at 25.

64. *Id.*

65. *See* South Dakota v. Dole, 483 U.S. 203, 208–09 (1987) (upholding Congress' use of the Spending Clause to incentivize states to bring their minimum drinking ages up to twenty-one).

66. *See* Whipple v. Martinson, 256 U.S. 41, 45 (1921) (affirming the authority of a state to "exercise . . . its police power to regulate the administration, sale, prescription and use of dangerous and habit-forming drugs").

67. UNIF. NARCOTIC DRUG ACT, § 2, 9B U.L.A. 423 (NAT'L CONF. OF COMM'RS ON UNIF. STATE L. 1932).

68. *See generally* Pub. L. No. 91-513, 84 Stat. 1236 (1970) (codified as amended at 21 U.S.C. §§ 801–971) (creating five drug schedules and implementing the National Convention on Narcotic Drugs, among other actions).

69. *See* 21 U.S.C. § 812.

70. *See* Rachel E. Barkow, *The Evolving Role of the United States Sentencing Commission*, 33 FED. SENT'G REP. 3, 4–5 (2020).

71. *See* Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3,207 (codified as amended at 21 U.S.C. § 841) (strengthening federal efforts at "eradicating" illicit drug sales and use).

minimums for "crack" and "powder" cocaine,[72] respectively, a ratio that has since been reduced to eighteen-to-one through the Fair Sentencing Act.[73]

Today, the significant social costs and public health consequences of alcohol and drugs are well documented.[74] The retributive impulses of the 1980s have tempered somewhat. A rehabilitative approach to low-level, nonviolent drug and alcohol offenses, typified by drug courts and similar treatment-centric programs, has emerged as an effective, evidence-based alternative to incarceration.[75] Moreover, there is an understanding that incarceration as a response to drug-related offenses carries significant, generational costs of its own. As Judge Amal Thapar has observed, "Kids who lost their parents to drugs . . . will now lose them again to jail. With broken homes and terrible role models, they, too, are likely to turn to drugs."[76] While marijuana continues to be listed as a prohibited substance under federal law, a growing number of states have permitted the medical use of marijuana or decriminalized the recreational possession and use of marijuana,[77] signaling shifting social attitudes towards—and commensurate legal treatment of—at least this drug and perhaps drugs more generally.

B. *The Disease Model*

At the time of Prohibition, the medical community was split as to whether alcohol was a medical or moral issue.[78] Today, consistent with Rush's writings, addiction is largely understood to be a disease.[79]

Alcohol and drugs impact the brain in three primary ways. First, they "over-activate" the pleasure center or reward circuit of the brain, known as the

72. *Compare* 21 U.S.C. § 841(b)(1)(B)(ii) (setting the mandatory minimum for powder cocaine at 500 grams), *with id.* § 841(b)(1)(B)(iii) (setting the mandatory minimum for crack cocaine at 5 grams).

73. Pub. L. No. 111-220, 124 Stat. 2,373 (2010) (codified as amended at 21 U.S.C. § 841(b)(B)(ii)–(iii)).

74. *See generally* Birchfield v. North Dakota, 136 S. Ct. 2160, 2166–72 (2016) (explaining the history of alcohol laws and accidents in the United States to contextualize the three alcohol-related accidents before the Court).

75. *See infra* notes 353–58 and accompanying text.

76. Amul Thapar, *The Prescription Drug Epidemic: A Federal Judge's Perspective*, PARTNERSHIP TO END ADDICTION (May 2011), https://drugfree.org/learn/drug-and-alcohol-news/the-prescription-drug-epidemic-a-federal-judges-perspective/ [https://perma.cc/KSK2-6LAD].

77. *See* Natalie Fertig & Mona Zhang, *1 in 3 Americans Now Lives in a State Where Recreational Marijuana Is Legal*, POLITICO (Nov. 4, 2020), https://www.politico.com/news/2020/11/04/1-in-3-americans-lives-where-recreational-marijuana-legal-434004 [https://perma.cc/WRT3-NVDP].

78. Michael M. O'Hear, *Federalism and Drug Control*, 57 VAND. L. REV. 783, 794 n.51 (2004) ("[I]n a 1918 survey of health officials, 425 reported that physicians viewed addiction as a disease, while 542 stated that addiction was instead viewed as a vice.").

79. *See* Nora D. Volkow, George F. Koob & A. Thomas McLellan, *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENG. J. MED. 363, 363 (2016) ("[N]euroscience continues to support the brain disease model of addiction.").

basal ganglia.[80] Accordingly, an individual who drinks or uses may feel enhanced euphoria in response to ingesting alcohol or drugs.[81] Despite the euphoria or "buzz" generated by alcohol, it is "classified . . . as a depressant because it later causes sedation and drowsiness."[82] If heavily consumed, "alcohol can induce unconsciousness, coma, and even death."[83] Opiate consumption produces a "surge of dopamine," akin to "a tidal wave in the reward circuits of the brain."[84] A person on heroin recounts "feel[ing] like a master of the universe, like you're being 'hugged by Jesus,'" as if "there's peace in your skin and not a single feeling of pain."[85] Cocaine and methamphetamine are examples of stimulants, though they differ in how they produce stimulating effects: cocaine blocks dopamine from reabsorption, keeping it in circulation, whereas methamphetamine increases dopamine output.[86] A person who drinks or uses drugs may increasingly crave and desire the substance due to these seemingly positive effects of the substance.[87] With repeated use of the intoxicating substance, the individual develops a tolerance: the brain becomes accustomed to the alcohol or drug, and thus the person must introduce more of the alcohol or drug into their system to trigger the desired pleasurable response.[88]

Second, once the body processes the alcohol or drugs and pleasurable feelings correspondingly fade, the extended amygdala—or stress-center of the brain—becomes particularly sensitive and the individual experiences symptoms associated with withdrawal, such as irritability and anxiety.[89] Thus, an individual may seek out and ingest additional alcohol or drugs to reduce these symptoms, as opposed to the original objective of consumption—namely achieving or enhancing pleasure.[90] Ceasing use following prolonged periods of use can generate acute symptoms of withdrawal. When an individual "detoxes," or stops using in order to detoxify and rid the body of the alcohol

80. *Drugs, Brains, and Behavior: The Science of Addiction*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain [https://perma.cc/FZ2D-7LU5] (last updated July 2018) [hereinafter *Drugs, Brains, and Behavior*].

81. *Id.*

82. Nat'l Insts. of Health, *Information About Alcohol*, NAT'L CTR. FOR BIOTECHNOLOGY INFO. (2007), https://www.ncbi.nlm.nih.gov/books/NBK20360/ [https://perma.cc/SNW9-ZQ6P].

83. *Id.*

84. Shreeya Sinha, *Heroin Addiction Explained: How Opioids Hijack the Brain*, N.Y. TIMES (Dec. 18, 2018), https://www.nytimes.com/interactive/2018/us/addiction-heroin-opioids.html [https://perma.cc/B39P-A4L2 (dark archive)].

85. *Id.*

86. *Methamphetamine Research Report*, NAT'L INST. ON DRUG ABUSE (Oct. 2019), https://www.drugabuse.gov/publications/research-reports/methamphetamine/how-methamphetamine-different-other-stimulants-such-cocaine [https://perma.cc/3BKF-59G5].

87. *Drugs, Brains, and Behavior*, *supra* note 8080.

88. *Id.*

89. *Id.*80

90. *Id.*

or drugs and their lingering physical effects, the individual's bodily response can be severe, including hallucinations, vomiting, and incontinence.[91] Third, alcohol and drugs impact the prefrontal cortex, the decision-making center of the brain.[92] A person's judgment may be impaired, and inhibitions may be lowered, while alcohol or drugs are in their system.[93]

Alcohol and drugs affect other parts of the body, too. The specific physical and psychological effects of intoxicating substances are not the same for all such substances but depend on various factors, including interactions with other drugs or medication, the amount of use, and the type of substance.[94] Heroin, for example, attaches to the central nervous system and leads to respiratory depression.[95] When an individual overdoses on heroin, respiration slows and can fail altogether.[96] To combat the decrease in respiration during an overdose, Naloxone can be administered (generally as a nasal form called Narcan).[97] Naloxone can save the life of an individual experiencing heroin overdose by blocking heroin's receptors, thus diminishing respiratory depression and restoring normal, automated breathing functions.[98]

C. *Medical and Therapeutic Treatment*

The disease model of addiction informs the prevailing view that addiction itself is the product of multiple factors and can be treated. Heart

91. *Id.*; *see also* Julia O'Malley, *Hooked, Part 3: Cravings Come at Night Taunting Her*, ANCHORAGE DAILY NEWS (Sept. 29, 2019), https://www.adn.com/features/article/heroin-promises-relief-daily-struggle/2010/06/22/ [https://perma.cc/HL4A-FWBY] ("It feels like the worst flu you've ever had. Your body aches. Your skin hurts. You sweat. You puke. You can't control your bowels. Dread consumes you."); Sinha, *supra* note 84 ("[Withdrawal] might [include] crippling pain, vomiting, insomnia, spasms, hot and cold flashes, goosebumps, congestion and tears. All this on top of debilitating anxiety and depression."). In addition to immediate withdrawal, an individual who ceases to use drugs or alcohol may experience prolonged withdrawal symptoms lasting up to two years, referred to as Post-Acute Withdrawal Symptoms or PAWS. *See* Steven M. Melemis, *Relapse Prevention and the Five Rules of Recovery*, 88 YALE J. BIO. MED. 325, 328 (2015) (describing the symptoms of such post-acute withdrawal).

92. *Drugs, Brains, and Behavior*, *supra* note 80.

93. *Id.*

94. For a helpful chart on the precise effects that correspond with particular substances, see generally NAT'L INST. ON DRUG ABUSE, PHYSICAL AND PSYCHOLOGICAL EFFECTS OF SUBSTANCE USE (2004), https://ncsacw.samhsa.gov/files/TrainingPackage/MOD2/PhysicalandPsychEffectsSubstanceUse.pdf [https://perma.cc/LHZ2-KNT2].

95. Caroline J. Jolley, James Bell, Gerrard F. Rafferty, John Moxham & John Strang, *Understanding Heroin Overdose: A Study of the Acute Respiratory Depressant Effects of Injected Pharmaceutical Heroin*, PLOS ONE, Oct. 23, 2015, at 10.

96. *Id.* at 2.

97. *See Naloxone*, SUBSTANCE ABUSE MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone [https://perma.cc/PZ5U-OT6Y] (last updated Aug. 19, 2020).

98. *Id.*

disease, for example, has genetic, social, and other causes;[99] so too does addiction.[100] Heart disease may be treated through medical and other means;[101] so too can addiction.[102]

Addiction treatment responds to and is dependent upon the needs and circumstances of the individual.[103] It may be helpful to consider treatment options along a continuum. On the acute end of the spectrum, a person who has used a substance in heavy amounts for an extended duration may need to detox, during which the effects of withdrawal from immediate cessation can be monitored in a hospital or inpatient setting, and/or managed through medication.[104] Once the person is physically stable, they may be referred for inpatient or outpatient treatment.[105] The former is more appropriate for an individual who does not have a stable living situation (such as someone who has been asked not to return to their house or who lives with others who actively drink or use) or who requires a high level of care (for example,

99. *See* Edward P. Havranek, Mahasin S. Mujahid, Donald A. Barr, Irene V. Blair, Meryl S. Cohen, Salvador Cruz-Flores, George Davey-Smith, Cheryl R. Dennison-Himmelfarb, Michael S. Lauer, Debra W. Lockwood, Milagros Rosal & Clyde W. Yancy, *Social Determinants of Risks and Outcomes for Cardiovascular Disease: A Scientific Statement from the American Heart Association*, 132 CIRCULATION 873, 888 (2015) ("[A]lthough we have traditionally considered CVD the consequence of certain modifiable and nonmodifiable physiological, lifestyle, and genetic risk factors, we must now broaden the focus to incorporate a third arm of risk, the social determinants of health.").

100. *See Substance Abuse: Life Stages & Determinants*, OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Substance-Abuse/determinants [https://perma.cc/L252-LEYM] (listing several determinants of substance abuse).

101. *See* NAT'L HEART, LUNG, & BLOOD INST., IN BRIEF: YOUR GUIDE TO LIVING WELL WITH HEART DISEASE 1 (2006), https://www.nhlbi.nih.gov/sites/default/files/publications/06-5716.pdf [https://perma.cc/SVN9-YWCD] ("Heart disease . . . can be treated in three ways: by making heart healthy changes in your daily habits, by taking medication, and in some cases, by having a medical procedure.").

102. *See What Is a Substance Abuse Disorder?*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/addiction/what-is-addiction [https://perma.cc/T7TT-MSQ4] ("Because [a Substance Abuse Disorder] affects many aspects of a person's life, multiple types of treatment are often required. . . . Medications are used to control drug cravings, relieve severe symptoms of withdrawal, and prevent relapses. . . . Many people find mutual-aid groups helpful (Alcoholics Anonymous, Narcotics Anonymous, SMART Recover) [as well as s]elf-help groups that include family members (Al-Anon or Nar-Anon Family Groups).").

103. *See* NAT'L INST. ON DRUG ABUSE, TREATMENT APPROACHES FOR DRUG ADDICTION, 2 (2019), https://www.drugabuse.gov/sites/default/files/drugfacts-treatmentapproaches.pdf [https://perma.cc/9296-BSZA] ("No single treatment is right for everyone. . . . Effective treatment addresses all of the patient's needs, not just his or her drug use. . . . Treatment plans must be reviewed often and modified to fit the patient's changing needs.").

104. *Id.* ("Medications help suppress withdrawal symptoms during detoxification."); *see also Drug and Alcohol Detox*, ADDICTION CTR., https://www.addictioncenter.com/treatment/drug-and-alcohol-detox/ [https://perma.cc/D69M-PR59] ("Detoxification, or detox, is the process of letting the body remove the drugs in it. The purpose of detox is to safely manage withdrawal symptoms when someone stops taking drugs or alcohol.").

105. *Drugs, Brains, and Behavior*, *supra* note 80103.

someone who has been unable to improve in an outpatient environment).[106] Typically, both inpatient and outpatient treatment involve a combination of individual therapy, group therapy, and medically assisted treatment ("MAT").[107] Individual therapy generally consists of the patient meeting with a licensed counselor or therapist to discuss the reasons for use, triggers, and other circumstances impacting the person's inability to achieve and maintain sobriety, and any related or co-occurring mental health issues, such as anxiety, trauma, or depression, that may impact the person's drinking or use.[108] Group therapy generally consists of peer-based support facilitated or supervised by a licensed counselor or therapist.[109] A group therapy session generally includes three components: an initial check-in part in which participants share how they are feeling or doing that day or since they were last in group; a part in which participants further discuss issues raised by other participants, using "I" statements as opposed to giving advice through "you" statements; and an educational part in which participants learn about coping mechanisms (for example, art therapy and meditation), forms of self-care, how the brain is impacted by addiction, and so on.[110]

MAT consists of the administration of appropriate medication for addiction and any co-occurring mental health disorders.[111] An individual with an addiction to alcohol, for example, may be given Antabuse (which can make the individual physically ill if they ingest alcohol while on this medication and

106. *See id.* 103("Impatient or residential treatment can also be very effective, especially for those with more severe problems (including co-occurring disorders).").

107. *See Medications, Counseling, and Related Conditions*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., http://www.samhsa.gov/medication-assisted-treatment/treatment [https://perma.cc/DS6W-85CZ] [hereinafter *MAT Medications*] (defining MAT as "the use of medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders").

108. *See* NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 28 (3rd ed. 2018) [hereinafter *Principles of Drug Addiction*], https://www.drugabuse.gov/download/675/principles-drug-addiction-treatment-research-based-guide-third-edition.pdf?v=74dad603627bab89b93193918330c223 [https://perma.cc/2ZHN-8T7S] ("Individualized drug counseling not only focuses on reducing or stopping illicit drug or alcohol use; it also addresses related areas of impaired functioning . . . as well as the content and the structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized counseling helps the patient develop coping strategies and tools to abstain from drug use and maintain abstinence.").

109. *Id.* (detailing how group therapy may "capitalize on the social reinforcement offered by peer discussion and to help promote drug-free lifestyles"); *see also* CTR. FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE TREATMENT: GROUP THERAPY xv (2005) (discussing how "[i]n the hands of a skilled, well-trained group leader, the potential healing powers inherent in a group can be harnessed and directed to foster" positive outcomes).

110. *See* CTR. FOR SUBSTANCE ABUSE TREATMENT, *supra* note 109109109, at xvi–xvii (describing the advantages of group therapy as including "positive peer support; a reduction in clients' sense of isolation; real-life examples of people in recovery; help from peers in coping with substance abuse and other life problems; [and] information and feedback from peers").

111. *See MAT Medications*, *supra* note 107.

thus serves as a deterrent to drinking alcohol),[112] or Vivitrol (which blocks the ability of the individual to experience euphoria from alcohol).[113] Aside from the precise effect, the length of the effect also is an important distinction between the two medications. Antabuse lasts in the body for several days and Vivitrol for several weeks.[114] MAT, during detox and the post-detox phase, also may include maintenance medications, such as suboxone, methadone, or buprenorphine, which are prescribed opiates designed to minimize physical dependence and the effects of acute withdrawal.[115]

Inpatient and outpatient treatment typically lasts for one to two months.[116] An overarching goal of such treatment is to put the individual in a position to develop their own support structure that they will then be able to rely upon when formal rehabilitation ends.[117] When an individual enters treatment, they may be encouraged or expected to attend ninety twelve-step meetings in ninety days (known as the "90 in 90"), based on the belief that it takes ninety days for the brain to learn and develop a new habit, to ensure that the individual develops their own independent support system.[118] During a rehabilitation program, an individual also may be encouraged or expected to obtain a sponsor, who is typically someone with extended "clean time" who has completed or "worked" a twelve-step program and who can serve as a mentor, guide, and advisor during the recovery process.[119] Once a rehabilitation program is over, the participant may be encouraged to attend twelve-step meetings, be actively meeting with their sponsor, and serve the recovery community.

112. *Using Disulfiram To Treat Alcoholism and Alcohol Abuse*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/addiction-medications/disulfiram [https://perma.cc/4G9T-MZTA] (last updated June 19, 2019).

113. *Overview of Vivitrol (Naltrexone)*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/addiction-medications/vivitrol [https://perma.cc/KLR4-5ENK] (last updated Feb. 4, 2020).

114. *Id.*

115. *See MAT Medications*, *supra* note 107107; *see also* Sinha, *supra* note 84 ("[Buprenorphine, methadone, and naltrexone] soften the cravings without causing euphoria.").

116. *See* Matt Gonzales, *How Long Does Rehab Take?*, DRUGREHAB.COM, https://www.drugrehab.com/treatment/how-long-does-rehab-take/ [https://perma.cc/DB5A-N9VS] (last updated Feb. 26, 2020).

117. *See Principles of Drug Addiction*, *supra* note 108, at 9 ("In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community.").

118. *See 90 Meetings in 90 Days*, LION ROCK RECOVERY, https://www.lionrockrecovery.com/drug-and-alcohol-addiction-resources/advice/90-meetings-in-90-days [https://perma.cc/XJR4-ZDA5].

119. *See Principles of Drug Addiction*, *supra* note 108, at 28 ("Self-help groups can complement and extend the effects of professional treatment."); *see also* ALCOHOLICS ANONYMOUS, QUESTIONS AND ANSWERS ON SPONSORSHIP 13 (2019) (describing the vital role of a sponsor as doing "everything possible . . . to help the newcomer get sober and stay sober through the A.A. program").

Twelve-step meetings, such as Alcoholics Anonymous ("AA") and Narcotics Anonymous ("NA"), offer the individual a practical blueprint for recovery, beginning with a desire to be sober and an acknowledgment that the individual is incapable of achieving and maintaining sobriety on their own.[120] Both AA and NA tout recovery through fellowship, and the organization and meetings themselves espouse equality and volunteerism and lack any rigid hierarchy.[121] Twelve-step meetings are not monolithic: some involve a single person providing opening comments (a "lead") that may contain a theme or question that other individuals can, but need not, address during their comments (or "share"); some involve speakers, much like a lecture about one's journey from active addiction to recovery; and still others may involve reading from and commenting on AA or NA literature.[122] In addition to AA or NA, there are other fellowship meetings, such as SMART Recovery (which may be distinguished from AA and NA in that these meetings do not include any element of a higher power and also permit cross-talk),[123] Celebrate Recovery (which bills itself as a "Christ-centered 12-step program"),[124] and Refuge Recovery (a spiritual or mindfulness-based approach based principally on a book by Noah Levine).[125]

Benjamin Rush, who helped pioneer the disease model of addiction, suggested that an individual with drug or alcohol disease abstain completely from these substances.[126] Abstinence remains, for some, a core component of

120. *See* ALCOHOLICS ANONYMOUS, THE TWELVE STEPS AND THE TWELVE TRADITIONS 21 (77th ed. 2012) ("We admitted we were powerless over alcohol—that our lives had become unmanageable."); NARCOTICS ANONYMOUS, INSTITUTIONAL GROUP GUIDE, TWELVE STEPS OF NARCOTICS ANONYMOUS 2 (1998) ("We admitted that we were powerless over our addiction, that our lives had become unmanageable.").

121. *See* ALCOHOLICS ANONYMOUS, DAILY REFLECTIONS, at Feb. 8 (1990) [hereinafter DAILY REFLECTIONS] ("Regular attendance at meetings, serving and helping others is the recipe that many have tried and found to be successful."); ALCOHOLICS ANONYMOUS, A.A. FACT FILE 4 (2018) [hereinafter A.A. FACT FILE], https://www.aa.org/assets/en_US/m-24_aafactfile.pdf [https://perma.cc/BR6A-Y839] ("Alcoholics Anonymous is not organized in the formal or political sense. There are no governing officers, no rules or regulations, no fees or dues.").

122. *See* Buddy T, *Going to Your First 12-Step Meeting*, VERYWELL MIND, https://www.verywellmind.com/what-can-i-expect-at-a-12-step-meeting-63409 [https://perma.cc/Y8WD-NBGC] (last updated May 22, 2020) ("Different meetings have different ways of doing things . . . . In some meetings, people are randomly called on . . . . In other meetings, at the end of the prayer, everyone may say a popular AA slogan . . . .").

123. *See SMART Recovery Meetings Cross 2,000 Mark, Including 1,000 in U.S.*, SMART RECOVERY (Mar. 28, 2016), https://smartrecovery.org/wp-content/uploads/2017/04/2000thMeeting.pdf [https://perma.cc/H9ET-N7XM].

124. *See* CELEBRATE RECOVERY, https://www.celebraterecovery.com [https://perma.cc/ZAG8-NXW3].

125. NOAH LEVINE, REFUGE RECOVERY: A BUDDHIST PATH TO RECOVERING FROM ADDICTION (2014).

126. BENJAMIN RUSH, AN INQUIRY INTO THE EFFECTS OF ARDENT SPIRITS UPON THE HUMAN BODY AND MIND 36 (8th ed. 1823) ("[M]y observations authorize me to say; that persons who have been addicted to them, should abstain from them suddenly and entirely. 'Taste not, handle

addiction treatment and recovery.[127] Twelve-step programs also subscribe to the proposition that an individual who seeks to address addiction must abstain from not only the drug of choice but from all other drugs as well.[128] A person with an addiction to alcohol, therefore, would not be permitted to ingest marijuana or another drug. The use of medications that may be habit-forming also would be counseled against under an abstinence model.

A growing alternative to the abstinence model is the harm-reduction model, typified by safe injection sites in which an individual with substance use disorder is offered "medically supervised consumption and observation rooms" and is encouraged to enter treatment.[129] The federal government has argued, and the Third Circuit recently agreed, that these safe consumption sites are inconsistent with federal law.[130] Nonetheless, these sites do have the support of some members of the medical community, including the American Medical Association.[131]

The threshold consideration of whether an individual has an addiction to alcohol or drugs takes the form of an intake assessment conducted by a licensed counselor or therapist.[132] The leading reference guide for clinical addiction professionals is the Diagnostic and Statistical Manual of Mental Disorders ("DSM-V"), published by the American Psychiatric Association.[133] The DSM-V categorizes substance abuse and alcohol abuse as "disorders."[134] The DSM-V suggests a holistic assessment of whether an individual possesses either disorder, listing eleven factors (for example, "unsuccessful efforts" to

not, touch not,' should be inscribed upon every vessel that contains spirits in the house of a man, who wishes to be cured of habits of intemperance.").

127. *See* A.A. FACT FILE, *supra* note 121, at 9120; NARCOTICS ANONYMOUS, *supra* note 120.

128. *See* A.A. FACT FILE, *supra* note 121, at 9; NARCOTICS ANONYMOUS, *supra* note 120.

129. United States v. Safehouse, 408 F. Supp. 3d 583, 586 (E.D. Pa. 2019).

130. *See* Motion for Summary Judgment at 2, United States v. Safehouse, 2020 WL 906997 (E.D. Pa. Jan. 17, 2020) (No. 19-0519), 2020 WL 562321, at *2 (calling the "'safe' injection site" a "radical public health experiment" that "violates the plain language of 21 U.S.C. § 856(a)(2), which makes it a crime to manage or control any place and 'knowingly and intentionally' make the place available for unlawfully using a controlled substance"); United States v. Safehouse, 985 F.3d 225, 243 (3d Cir. 2021) (holding that the consumption rooms were unlawful).

131. *See* Press Release, *AMA Wants New Approaches To Combat Synthetic and Injectable Drugs*, AM. MED. ASS'N (June 12, 2017), http://www.ama-assn.org/press-center/press-releases/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs [https://perma.cc/FTY8-58QQ] ("[T]he AMA today voted to support the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision.").

132. For a list of validated assessments, see *Screening and Assessment Tools Chart*, NAT'L INST. ON DRUG ABUSE (June 22, 2018), https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools [https://perma.cc/XY9Z-YRYP].

133. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5].

134. *Id.* at xlii ("The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders.").

curb consumption and "tolerance") to guide that assessment.[135] An individual must manifest at least two factors in a twelve-month period to qualify for substance use disorder.[136] An individual with a mild presentation of the disorder will possess two or three factors in that span, moderate four to five, and severe at least six.[137] Individuals with an addiction may not all drink or use in the same way: one need not drink or use daily or alone to qualify. One who goes on periodic binges in public, for example, can be an individual with an alcohol or substance use disorder, as may someone who drinks or uses every day.[138]

Despite the increased sense that addiction is a disease and not a moral failing, the social stigma associated with addiction persists.[139] This social

135. The eleven diagnostic criteria for alcohol use disorder are:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following: a. The characteristic withdrawal syndrome or alcohol . . . . b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Id. at 490–91. The diagnostic criteria for other substances are generally the same diagnostic criteria used for alcohol use disorder with only small variations. *See id.* at 509–10 (cannabis use disorder); *id.* at 520 (phencyclidine use disorder); *id.* at 533–34 (inhalant use disorder); *id.* at 541 (opioid use disorder); *id.* at 550–51 (sedative, hypnotic, or anxiolytic use disorder); *id.* at 561 (stimulant use disorder—including cocaine).

136. *Id.* at 490.

137. *Id.* at 484. AA and NA similarly pose a series of questions to help the individual determine whether they may have a problem.

138. *See Researchers Identify Alcoholism Subtypes*, NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM (June 28, 2007), https://www.niaaa.nih.gov/news-events/news-releases/researchers-identify-alcoholism-subtypes [https://perma.cc/R85T-CTQL]; Bankole A. Johnson, *Medication Treatment of Different Types of Alcoholism*, 167 AM. J. PSYCHIATRY 630, 630 (2010).

139. *See, e.g.*, Stephanie Desmon & Susan Morrow, *Drug Addiction Viewed More Negatively Than Mental Illness, Johns Hopkins Study Shows*, JOHNS HOPKINS UNIV. (Oct. 1, 2014), https://hub.jhu.edu/

stigma has existed from the founding of our nation. Those who sought to boot a federal judge from office charged as a reason for impeachment that he had "bad moral character due to drunkenness."[140] (Today, a federal judge whose drinking is a concern would be referred to a committee within Article III governing judicial disability).[141] In the twentieth century, members of the Supreme Court acknowledged the "harsh moral attitude which our society has traditionally taken toward intoxication and the shame which we have associated with alcoholism," further observing that "Anglo-American society has long condemned [alcoholism] as a moral defect" and "cultural taboo."[142] Unfavorable public perceptions of individuals with drug or alcohol diseases are easy to find among the public,[143] in popular culture,[144] and even among physicians.[145] Stigma contributes to individuals with drug or alcohol diseases

2014/10/01/drug-addiction-stigma/ [https://perma.cc/KHT8-BSQ2] (summarizing a study in which respondents reported disinterest in working with a person with an addiction and noting that respondents continue to believe that addiction is a moral failing).

140. MAVEETY, *supra* note 26, at 12.

141. 28 U.S.C. §§ 351–364.

142. Powell v. Texas, 392 U.S. 514, 531 (1968).

143. *See, e.g.*, K.M. Keyes, M.L. Hatzenbuehler, K.A. McLaughlin, B. Link, M. Offoson, B.F. Grant & D. Hasin, *Stigma and Treatment for Alcohol Disorders in the United States*, 172 AM. J. EPIDEMIOLOGY 1364, 1365 (2010) ("Alcohol disorders are among the most highly stigmatized of the psychiatric disorders. For example, public perceptions of individuals with alcohol disorders include negative labels, such as dangerous, immoral, and blameworthy."); Georg Schomerus, Michael Lucht, Anita Holzinger, Herbert Matschinger, Mauro G. Carta & Matthias C. Angermeyer, *The Stigma of Alcohol Dependence Compared with Other Mental Disorders: A Review of Population Studies*, 46 ALCOHOL & ALCOHOLISM 105, 105 (2011) (describing the negative consequences of alcohol dependence and noting that "[t]he stigma of alcoholism is likely to aggravate these effects; it may hinder the seeking of professional and lay help, because people fear being labelled alcoholics and subsequently experiencing loss of status and discrimination"); Georg Schomerus, *The Stigma of Alcohol and Other Substance Abuse*, *in* THE STIGMA OF DISEASE AND DISABILITY: UNDERSTANDING CAUSES AND OVERCOMING INJUSTICES 57, 57–58 (Patrick W. Corrigan ed., 2014).

144. In *Breaking Bad*, for example, Walter White calls his former student Jesse Pinkman a "pathetic junkie," adding, "You are *just* a drug addict." *Breaking Bad: Down* (AMC television broadcast Mar. 29, 2009). Likewise, in *The Wire*, D'Angelo Barksdale, a mid-level player in a drug distribution ring, calls out his subordinates for their dismissive attitude towards a customer who is looking for heroin. Barksdale protests their treating "him like a dog," arguing, "You ain't gotta punk em like that." *The Wire: The Buys* (HBO television broadcast June 16, 2002). The street-level dealers justify their attitude by suggesting the individual with drug or alcohol disease deserves or invites such treatment: "He punked hisself. [sic] He a goddamn addict," emphasizing again, "they [just] dope fiends." *Id.*

145. *See* Schomerus et al., *supra* note 143, at 59; Leonieke C. van Boekel, Evelien P.M. Brouwers, Jaap van Weeghel & Henk F.L. Garretsen, *Stigma Among Health Professionals Towards Patients with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systemic Review*, 131 DRUG & ALCOHOL DEPENDENCE 23, 24 (2013); Cecelia Kathleen Mendiola, Giorgio Galetto & Michael Fingerhood, *An Exploration of Emergency Physicians' Attitudes Towards Patients with Substance Use Disorder*, 12 J. ADDICTION MED. 132, 132 (2018).

internalizing these negative attitudes and experiencing shame, embarrassment, and similar feelings, and in turn not coming forward to seek help.[146]

While the disease model is prevalent, it is not without criticism. A leading objection to the disease model points to research indicating that some individuals who seemed at one time to be addicted to alcohol or drugs are able, without treatment, to resume consumption of their drug of choice without exhibiting the adverse consequences suggesting an addiction.[147] In an oft-quoted study, approximately fifteen to twenty percent of American soldiers who served in the Vietnam War were addicted to heroin, but of those who returned home, only five percent exhibited an addiction within the following year and only twelve percent relapsed within three years.[148] This transformation apparently occurred "overnight" and "spontaneously," without the aid of formal rehabilitation.[149]

Another major criticism of the disease model derives from its insistence that the individual with drug or alcohol disease abstain from alcohol or drugs. This insistence is predicated on the proposition that an individual with drug or alcohol disease cannot ingest any healthy amount of alcohol or drugs. Studies on controlled drinking suggest, however, that certain individuals with addiction may be able to ingest alcohol without giving rise to the negative factors that indicate an addiction to alcohol.[150] To be fair, according to this research, only some are able to return to drinking that is not problematic; the more one is dependent on alcohol, the less likely that such a return is possible.[151] The ability of some to safely return to alcohol cuts against, for critics, the disease model's categorical insistence on abstinence.

* * *

This part explained the historical, physiological, and corrective components of addiction. This descriptive overview established a factual foundation for the next part on how the law has addressed addiction.

146. *See* Gail D'Onfrio, *Fight the Opioid Epidemic with Stigma-Free Treatment*, CATO UNBOUND (Aug. 21, 2019), https://www.cato-unbound.org/2019/08/21/gail-donofrio/fight-opioid-epidemic-stigma-free-treatment [https://perma.cc/E2WP-U4P9].

147. *See* Nick Heather, *Is the Concept of Compulsion Useful in the Explanation or Description of Addictive Behavior and Experience?*, 6 ADDICTIVE BEHAV. REPS. 15, 27–28 (2017); Lee N. Robins, *Vietnam Veterans' Rapid Recovery from Heroin Addiction: A Fluke or Normal Expectation?*, 88 ADDICTION 1041, 1053 (1993).

148. JAMES CLEAR, ATOMIC HABITS: AN EASY & PROVEN WAY TO BUILD GOOD HABITS & BREAK BAD ONES 91 (2018).

149. *Id.* at 92.

150. *See* William R. Miller, *Controlled Drinking: A History and a Critical Review*, 44 J. STUD. ON ALCOHOL 68, 78–79 (1983).

151. *See Alcohol Abstinence vs. Moderation*, HARV. MED. SCH. (Jan. 2009), http://www.health.harvard.edu/mind-and-mood/alcohol-abstinence-vs-moderation [https://perma.cc/YG48-JH6G].

II. LEGAL RESPONSES TO ADDICTION

This part describes how the courts have translated matters of addiction into legal concepts and rules. It first briefly sketches the relationship of addiction with four common criminal law concepts: voluntary intoxication, involuntary intoxication, temporary insanity, and fixed insanity. It then provides a detailed summary of the two Supreme Court cases—*Robinson* and *Powell*—on the criminal responsibility of individuals with an addiction to drugs or alcohol. Lastly, it summarizes the two legal models that have emerged from these two seminal cases.

A. *Intoxication and Insanity*

This section summarizes the primary and varied methods by which issues related to addiction have been introduced in criminal theory and litigation. A manifestation of addiction is intoxication, or heavy consumption that leads to impaired judgment, impaired motor functioning, and loss of inhibitions.[152] Circumstances in which intoxication and criminal law may intersect are easy to conceptualize. A criminal defendant may claim, for example, that criminal liability is not appropriate because they were intoxicated and the incident was completely out of character.

Voluntary Intoxication. In considering this line of argument, courts will probe whether the ingestion of the alcohol or drug producing the alleged state of intoxication was voluntary or involuntary. "Voluntary intoxication" occurs when an individual ingests a substance known by the individual to possess intoxicating properties.[153] The individual need not know the precise type or brand of substance for the ingestion to be voluntary; all that is required, other than the act of knowing ingestion, is knowledge that what the individual is putting into their system is of an intoxicating quality.[154] A person who goes to a party, drinks what they know to be alcohol, and becomes intoxicated from

152. The medical basis for these effects is discussed *supra* in Section I.B.

153. State v. Champagne, 447 P.3d 297, 317 (Ariz. 2019) (citing State v. Payne, 314 P.3d 1239, 1272–73 (Ariz. 2013)).

154. *See* Cribb v. State, 45 S.E. 396, 397 (Ga. 1903) ("There was no evidence on which to charge as to the effect of drugging the ale alleged to have been used by the defendant, nor can the courts establish a precedent which would authorize a chemical investigation as to whether the liquor was good or bad, pure or impure, drugged, or containing only malt, spirituous, or vinous qualities. Drunkenness voluntarily produced by one sort of liquor is no more an excuse for crime than that caused by any other kind of intoxicating drink."); State v. Bunn, 283 N.C. 444, 457, 196 S.E.2d 777, 786 (1973) ("'[I]nvoluntary intoxication is a very rare thing, and can never exist when the person intoxicated knows what he is drinking, and drinks the intoxicant voluntarily, and without being made to do so by force or coercion.' . . . Thus it is only when alcohol has been induced into a person's system without his knowledge or by force majeure that his intoxication will be regarded as involuntary.") (alteration in original) (citation omitted) (quoting Perryman v. State, 159 P. 937–38 (Okla. 1916)).

having several such drinks has become voluntarily intoxicated, despite the fact that they intended to drink without reaching a state of intoxication.

At common law, voluntary intoxication, where the ingestion was attributed to the free will of the defendant, did not excuse or otherwise diminish an individual's exposure to criminal liability.[155] Lord Hale, for example, wrote that he who became voluntarily intoxicated "shall have no privilege by this voluntary contracted madness, but shall have the same judgment as if he were in his right senses."[156] If anything, at common law, voluntary intoxication was deemed to be an aggravating factor in liability assessments. For example, Sir William Blackstone described voluntary intoxication "as an aggravation of the offence, rather than as an excuse for any criminal misbehaviour."[157] Early American jurisprudence is consistent with this strict common law approach to voluntary intoxication. Justice Story, reflecting both the common law tradition and the general social aversion to the intoxicated individual, asserted that "[d]runkenness is a gross vice, and in the contemplation of some of our laws is a crime; and I learned in my earlier studies, that so far from its being in law an excuse for murder, it is rather an aggravation of its malignity."[158]

In modern criminal cases, a prosecutor may rely on voluntary intoxication to help prove that the defendant had diminished inhibitions and thus was more capable of committing the act in question.[159] The prosecution also may point to the relevant behavior of the defendant to demonstrate capability and intent (such as, retrieving a weapon from a vehicle, or taking aim and shooting the victim in the head), to blunt the relevance of the intoxicated state of the defendant.[160] The defense generally will be unable to

155. *See* Jerome Hall, *Intoxication and Criminal Responsibility*, 57 HARV. L. REV. 1045, 1046 (1944) ("The early common law apparently made no concession whatever because of intoxication . . . .").

156. Montana v. Egelhoff, 518 U.S. 37, 44 (1996) (quoting 1 MATTHEW HALE, PLEAS OF THE CROWN *32–*33); *accord* Reniger v. Fogossa [1816] 75 Eng. Rep. 1, 31 (KB) ("[I]f a person that is drunk kills another, this shall be felony, and he shall be hanged for it, and yet he did it through ignorance, for when he was drunk he had no understanding nor memory; but inasmuch as that ignorance was occasioned by his own act and folly, and he might have avoided it, he shall not be privileged thereby.").

157. *Egelhoff*, 518 U.S. at 44 (quoting 4 WILLIAM BLACKSTONE, COMMENTARIES *25–*26).

158. United States v. Cornell, 25 F. Cas. 650, 657–58 (C.C. R.I. 1820) (No. 14,868).

159. *See* State v. Payette, 38 A.3d 1120, 1127 (R.I. 2012) ("A claim of diminished capacity will negate the specific intent charged *only if* the intoxication is found to be 'of such a degree as to completely paralyze the will of the [defendant], take from him the power to withstand evil impulses[,] and render his mind incapable of forming any sane design.'" (alteration in original) (emphasis added)).

160. *See, e.g.*, Lewellyn v. State, 523 N.E.2d 768, 768 (Ind. Ct. App. 1988) (noting that voluntary intoxication did not render defendant incapable of forming necessary intent to commit crime, as evidenced by the fact that the "[defendant] threatened to shoot [the victim]. Then [the defendant] walked to a gun cabinet, removed a pump shotgun, pumped the gun, turned and shot [the victim] in the chest").

use voluntary intoxication to negate criminal responsibility because of the principle that the intoxication can be traced to the individual's free will. But the defense may challenge whether the defendant was capable of carrying out the crime due to an intoxicated state (for example, if the defendant was passed out)[161] or whether the defendant possessed the mental state required under the statute (in other words, whether the defendant intended to commit the act).[162]

Involuntary Intoxication. In contrast to voluntary intoxication, "involuntary intoxication" generally occurs when the ingestion of a substance with intoxicating properties, or that produces an unexpected intoxicating effect, is not the product of the individual's free will.[163] In general, involuntary intoxication occurs in one of two circumstances: First, when the involuntariness is attributable to a third party, such as a person who compels or tricks the individual into ingesting an intoxicant[164] or a medical professional who prescribes a substance with an unforeseeable intoxicating effect.[165] Second, when the involuntariness is attributable to the individual ingesting the intoxicant, such as an individual who accidentally ingests a substance with an unforeseeable intoxicating effect[166] or an individual who knowingly ingests a substance that produces an abnormal or unexpected reaction of intoxication.[167] At both common law and at present, involuntary intoxication negates criminal liability.[168]

161. *See* Allan E. Korpela, Annotation, *Prosecution of Chronic Alcoholic for Drunkenness Offenses*, 40 A.L.R.3d 321 (1971) (first citing Driver v. Hinnant, 356 F.2d 761 (4th Cir. 1966); then citing Easter v. District of Columbia, 361 F.2d 50 (D.C. Cir. 1966); then citing State v. Fearon, 166 N.W.2d 720 (Minn. 1969); and then citing City of Seattle v. Hill, 435 P.2d 692 (Wash. 1967)).

162. *See generally* R.W. Gascoyne, Annotation, *Modern Status of the Rules as to Voluntary Intoxication as Defense to Criminal Charge*, 8 A.L.R.3d 1236 (1966) (discussing cases where the defendant argued their alcoholism prevented the defendant from having the requisite intent to commit the crime).

163. *See* Sallahdin v. Gibson, 275 F.3d 1211, 1236 (10th Cir. 2002) ("Involuntary intoxication results from fraud, trickery or duress of another, accident or mistake on defendant's part, pathological condition, or ignorance as to the effect of prescribed medication.").

164. *See* Phillip E. Hassman, Annotation, *When Intoxication Deemed Involuntary so as To Constitute a Defense to Criminal Charge*, 73 A.L.R.3d 195 (1976) (first citing United States v. Jewett, 438 F.2d 495 (8th Cir. 1971); then citing Burrows v. State, 297 P. 1029 (Ariz. 1931); then citing People v. White, 264 N.E.2d 228 (Ill. App. Ct. 1970); and then citing People v. Scott, 194 Cal. Rptr. 633 (Cal. Ct. App. 1983)).

165. *See id.* (first citing Perkins v. United States, 228 F. 408 (4th Cir. 1915); then citing Johnson v. State, 24 So. 2d 228 (Ala. Ct. App. 1945); then citing Boswell v. State, 610 So. 2d 670 (Fla. Dist. Ct. App. 1992); and then citing Saldiveri v. State, 143 A.2d 70 (Md. 1958)).

166. *See id.* (first citing State v. Voorhees, 596 N.W.2d 241 (Minn. 1999); then citing People v. Penman, 110 N.E. 894 (Ill. 1915); and then citing Dubs v. State, 235 A.2d 764 (Md. Ct. Spec. App. 1967)).

167. *See id.* (first citing Commonwealth v. Walker, 129 A. 453 (Pa. 1925); then citing People v. Low, 732 P.2d 622 (Colo. 1987); then citing Hurley v. Commonwealth, 451 S.W.2d 838 (Ky. 1970); and then citing Sluyter v. State, 941 So. 2d 1178 (Fla. Dist. Ct. App. 2006)).

168. *See id.*

While an individual who initially ingests a substance that produces unexpected or unanticipated adverse intoxicating effects may not be considered culpable, any continued use with knowledge of those adverse effects may not protect the individual from the ordinary operation or application of culpability principles.[169] This rule is consistent with tort law. For example, a driver who suffers an unforeseeable medical incident and crashes into another may escape civil liability, but if the driver subsequently engages in the same behavior, they would have a more difficult time claiming a lack of knowledge, culpability, and responsibility.[170] Consider the example of an individual who has had fainting spells and crashes a car while unconscious or asleep. The individual's knowledge of the condition that produced the loss of consciousness "is enough to make him guilty of a crime."[171]

Insanity. Insanity is another vehicle by which intoxication and addiction are raised in the criminal context. In general, insanity concerns whether the individual can appreciate the wrongfulness of their actions.[172] Temporary insanity speaks to a short-term inability, attributed to the ingestion of alcohol or drugs, to appreciate the wrongfulness of one's actions.[173] Whether temporary insanity may serve as a viable defense depends, as with voluntary and involuntary intoxication, on whether the temporary insanity was brought on by voluntary or involuntary conduct.[174]

169. *See id.* (first citing Montero v. State, 996 So. 2d 888 (Fla. Dist. Ct. App. 2008); and then citing People v. Mahle, 78 Cal. Rptr. 360 (Cal. Ct. App. 1969)).

170. S*ee* Timothy E. Travers, Annotation, *Liability for Automobile Accident Allegedly Caused by Driver's Blackout, Sudden Unconsciousness, or the Like*, 93 A.L.R.3d 326 (1979). *But see* Hassman, *supra* note 164 (explaining that an alcoholic drinking alcohol has been considered an involuntary act in a number of cases even if the defendant knowingly consumes the alcohol).

171. WAYNE R. LAFAVE, 1 SUBSTANTIVE CRIMINAL LAW § 6.1(c) (3d ed. 2018).

172. *See* United States v. Levine, 80 F.3d 129, 134 (5th Cir. 1996) ("In a case where the defendant asserts the affirmative defense of insanity, the ultimate issue is whether at the time of the crime the defendant 'appreciated the nature and quality or the wrongfulness of his acts.'"); United States v. Ewing, 494 F.3d 607, 612 (7th Cir. 2007) ("The prosecution conceded Ewing suffered from paranoid schizophrenia but argued he was not legally insane because he was able to appreciate the wrongfulness of his actions.").

173. *See* Phillip E. Hassman, *Effect of Voluntary Drug Intoxication upon Criminal Responsibility*, 73 A.L.R.3d 98 (1976) (describing that "[u]nderlying most attempts to gain recognition of voluntary drug intoxication as a defense to a criminal act is some form of an insanity defense; but it is a temporary insanity, a mental state that disappears when the effects of the drug wear off").

174. *See* United States v. F.D.L., 836 F.2d 1113, 1116 (8th Cir. 1988) (recognizing that, under an insanity defense, as with involuntary intoxication, "[t]he defendant is excused from criminality because intoxication affects the ability to distinguish between right and wrong"); *id.* at 1117 ("Congress in recently revising the Insanity defense statute specifically rejected voluntary intoxication as a defense even if it renders the defendant unable to appreciate the nature and quality of his acts."); *see also* Martin v. Scroggy, No. 86-6212, 1987 WL 38721, at *2 (6th Cir. Oct. 16, 1987) (rejecting defendant's proposed temporary insanity defense resulting from an abnormal reaction to alcohol).

Fixed Insanity. A defendant may seek to avoid criminal liability by invoking the doctrine of fixed or settled insanity. Under this doctrine, continued intoxication has produced or contributed to a permanent inability of the individual to appreciate the wrongfulness of their conduct.[175] Such a defense was recognized in early nineteenth-century English law, as reported by Lord Hale.[176] The concept found its way into American judicial opinions shortly thereafter.[177] As with insanity stemming from involuntary intoxication, settled insanity is a viable defense to criminal liability. Justice Story explains: "[I]nsanity, whose remote cause is habitual drunkenness, is, or is not, an excuse . . . for a [crime] committed by the party while so insane, but not at the time intoxicated, or under the influence of liquor. . . . [I]nsanity is an excuse for the commission of every crime."[178] That said, the settled insanity defense seems to be a narrow one, limited to those circumstances in which the individual is in a perpetual state of inability to appreciate or regulate his

175. *See* Greider v. Duckworth, 701 F.2d 1228, 1233 (7th Cir. 1983) ("While temporary mental incapacity induced by voluntary intoxication is generally not a defense, the law will not hold an accused responsible for his acts where the ingestion of intoxicants has been abused to the point that it has produced mental disease such that the accused is unable to appreciate the wrongfulness of his conduct or is unable to conform his conduct to the requirements of the law.").

176. *See* Parker v. State, 254 A.2d 381, 388 (Md. Ct. Spec. App. 1969) ("Hale, as the law does today, distinguished between temporary insanity caused by voluntary drunkenness and that caused by involuntary drunkenness and he recognized that permanent insanity, even though caused by voluntary drinking excused the commission of a crime. The rule of law with respect to responsibility for criminal conduct as affected by voluntary intoxication which has been consistently followed by the majority of courts in the United States is substantially that stated by Lord Hale.").

177. *See, e.g.*, Springer v. Collins, 586 F.2d 329, 333–34 (4th Cir. 1978) (citing *Parker*, 254 A.2d at 388); Jones v. Stephens, 157 F. Supp. 3d 623, 661 (N.D. Tex. 2016) (citing Evers v. State, 20 S.W. 744, 748 (Tex. Crim. App. 1892)); Bieber v. People, 856 P.2d 811, 815–16 (Colo. 1993).

178. United States v. Drew, 25 Fed. Cas. 913, 913 (C.C.D. Mass. 1828) (No. 14,993). A California court offers this helpful language:

> If [individual reason] is perverted or destroyed by fixed disease, though brought on by his own vices, the law holds him not accountable, but if, by a voluntary act, he temporarily casts off the restraints of reason and conscience, no wrong is done him if he is considered answerable for any injury which, in that state, he may do to others or to society . . . It must be "settled insanity", and not merely a temporary mental condition . . . which will relieve one of the responsibility of his criminal act.

Bieber, 856 P.2d at 815 (alteration in original) (quoting People v. Lim Dum Dong, 78 P.2d 1026, 1028 (Cal. Ct. App. 1938); *see also* Boswell v. Commonwealth, 61 Va. (20 Gratt.) 860, 872 (1871) ("If permanent insanity be produced by habitual drunkenness, then, like any other insanity, it excuses an act which would be otherwise criminal.").

conduct.[179] Possessing an addiction, by itself, will not suffice to demonstrate such insanity.[180]

B. *Supreme Court Guideposts*

The Supreme Court has handed down two cases—*Robinson* and *Powell*—on criminal law and addiction. This section summarizes these two seminal cases.

1. *Robinson*

On a street in Los Angeles, an officer noticed an individual whose arm had significant needle marks and scabs, consistent with repeated injection of narcotics from hypodermic needles.[181] The officer arrested the individual, Lawrence Robinson, for violating a state statute making it a misdemeanor for any person to be "addicted to the use of narcotics."[182] Robinson was not under the influence of narcotics at the time nor was he suffering from any withdrawal symptoms.[183] But he admitted to using narcotics in the past.[184] At the police station, another officer observed similar markings on Robinson's arms.[185]

A jury convicted Robinson, and an appeals court affirmed.[186] But in 1962, the Supreme Court reversed.[187] The Court expressed concern that the statute did not purport to cover any action (such as instant drug use or any antisocial conduct stemming from such use) nor did the statute refer the individual for medical treatment.[188] Even if the statute criminalized conduct, "involuntary confinement" for purposes of treatment could be appropriate, the Court noted.[189] Here, however, treatment was not ordered;[190] instead, a violation of the statute carried a sentence of between ninety days and one year in county

179. *See* Stephen J. Morse, *Addiction, Genetics, and Criminal Responsibility*, 69 L. & CONTEMP. PROBS. 165, 194 (2006) ("[E]xcept 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.").

180. *See* United States v. Stevens, 461 F.2d 317, 321 (7th Cir. 1972) (holding that the insanity defense is not required as a matter of law when defendant only referenced addiction); United States v. Coffman, 567 F.2d 960, 963 (10th Cir. 1977) (holding that the insanity defense is not required as a matter of law when "testimony . . . does no more than express the idea that a narcotics addict may be influenced by his appetite for drugs to commit a crime to support his habit").

181. Robinson v. California, 370 U.S 660, 661 (1962).

182. *Id.* at 660.

183. *Id.* at 662.

184. *Id.*

185. *Id.* at 661.

186. *Id.* at 663–64.

187. *Id.* at 668.

188. *Id.* at 666.

189. *Id.* at 665.

190. *Id.*

jail, with the possibility of probation of no more than five years.[191] The Court also acknowledged that "addiction is an illness," one that "may be contracted innocently or involuntarily," such as through "medically prescribed narcotics" or a mother's use during pregnancy.[192] With this understanding, the Court held that the statutory provision amounted to cruel and unusual punishment in violation of the Eighth Amendment.

Justice Douglas, known incidentally to be a heavy drinker,[193] concurred. He agreed that addiction is considered to be a "chronic disease" and a "mental or psychiatric disorder."[194] He suggested that punishing the individual with drug or alcohol disease in the hopes that they will "forsake their evil ways" is as foolish as punishing the insane as a method of reform or deterrence.[195] Indeed, Justice Douglas, citing a Senate Report, observed that "there is 'a hard core' of 'chronic and incurable drug addicts who, in reality, have lost their power of self-control.'"[196] As "[t]he addict is a sick person," he surmised, the individual should be treated and may be confined for purposes of treatment.[197] Accordingly, it is cruel and unusual for a statute to "penaliz[e] an illness."[198]

Justice Harlan concurred as well, writing that "on the present state of medical knowledge," California could "conclude that narcotics addiction is something other than an illness . . . ."[199] In this case, however, Robinson was punished without committing any act and, instead, simply for being an individual with an addiction to narcotics in California.[200]

Justice Clark dissented, arguing that the statute does not reach "a person who acted without volition or who had lost the power of self-control,"[201] but rather "applies to the incipient narcotic addict who retains self-control . . . ."[202] As to the application of the statute to the person who lacks self-control, Justice Clark noted that criminal law extends to status offenses, such as "drunkenness, which plainly is as involuntary after addiction to alcohol as is the taking of drugs."[203] The statute, according to Justice Clark, is justified by the legitimate goal of incapacitation as it seeks "to cure . . . by preventing further use."[204]

191. *Id.* at 660–61 n.1.
192. *Id.* at 667.
193. *See* Posner, *supra* note 26.
194. *Robinson*, 370 U.S. at 672, 675 (Douglas, J., concurring).
195. *Id.* at 669–70, 674.
196. *Id.* at 673.
197. *Id.* at 674.
198. *Id.* at 678.
199. *Id.* (Harlan, J., concurring).
200. *Id.*
201. *Id.* at 680 (Clark, J., dissenting).
202. *Id.* at 681; *see also id.* at 684 ("The section at issue applies only to persons who use narcotics often or even daily but not to the point of losing self-control.").
203. *Id.* at 684.
204. *Id.* at 681.

Justice Clark contended that addiction is "a condition commonly recognized as a threat to the State and to the individual"[205] and that California legitimately "may attempt to deter and prevent . . . the grave threat of future harmful conduct" arising from addiction.[206] Finally, Justice Clark pointed out that the defense did not dispute that Robinson's addiction may be traced to his own actions.[207]

Justice White also dissented, asserting that the statute was directed toward conduct, specifically "the regular, repeated or habitual use of narcotics."[208] But, critically, Justice White suggested that he may have voted differently if there was an indication that drug use was beyond Robinson's control.[209] "[I]f [Robinson] was convicted for being an addict who had lost his power of self-control," Justice White hypothesized, "I would have other thoughts about this case."[210] The Supreme Court would address the subject of addiction and voluntariness only six years later.

2. *Powell*

Leroy Powell, a shoe shiner from Texas, drank wine daily and got drunk about once a week.[211] When inebriated, Powell usually passed out in public.[212] He had been arrested approximately 100 times for public intoxication.[213] In late December 1966, Powell was arrested again for public intoxication.[214]

At trial, Powell claimed that he was "afflicted with the disease of chronic alcoholism," that being drunk in public was "not of his own volition," and that, as a result, "to punish him criminally for that conduct" would constitute cruel and unusual punishment.[215] In support of this contention, a psychiatrist testified that a "'chronic alcoholic' is an 'involuntary drinker,' who is 'powerless not to drink,' and who 'loses his self-control over his drinking.'"[216] Upon examining Powell, the psychiatrist concluded that Powell was a "chronic alcoholic" who, once intoxicated, "is not able to control his behavior" and who "reache[s] this point because he has an uncontrollable compulsion to drink."[217] That said, the psychiatrist acknowledged that, while sober, Powell could differentiate between right and wrong and that Powell's decision to take the

205. *Id.* at 679.
206. *Id.* at 683.
207. *Id.* at 684.
208. *Id.* at 686 (White, J., dissenting).
209. *Id.*
210. *Id.*
211. Powell v. Texas, 392 U.S. 514, 555 (1968) (Fortas, J., dissenting).
212. *Id.*
213. *Id.*
214. *Id.* at 517 (plurality opinion).
215. *Id.*
216. *Id.* at 518.
217. *Id.*

first drink was a "voluntary exercise of his will."[218] Despite his drinking history and related criminal record, Powell never received treatment.[219]

The morning of trial, Powell admitted to having a single drink before the proceedings started.[220] The prosecution suggested that Powell's ability to refrain from having any additional drinks demonstrated that Powell could exercise sufficient willpower to not become intoxicated.[221] The defense countered with the theory that Powell had only one drink because he only had enough money—he only made about $12 a week—for that one drink.[222]

The trial court found that "chronic alcoholism is a disease which destroys the afflicted person's will power to resist the constant, excessive consumption of alcohol," that "a chronic alcoholic does not appear in public by his own volition," and that Powell "is a chronic alcoholic who is afflicted with the disease of chronic alcoholism."[223] But the trial court ruled, as a matter of law, that chronic alcoholism was not a defense to the charge.[224] The trial court therefore upheld the conviction.[225]

If *Robinson* forbids states from punishing status, the Supreme Court in *Powell* addressed the question left open by *Robinson*, namely whether conduct that is symptomatic of addiction may not be punished either, "because it is, in some sense, 'involuntary' . . . ."[226] In an opinion authored by Justice Thurgood Marshall, a plurality of four Justices of the Supreme Court recognized the "widespread agreement today that 'alcoholism' is a 'disease . . . .'"[227] There was no consensus, however, as to what this medical determination meant for legal purposes, the plurality acknowledged.[228] Compounding the uncertainty, the plurality noted, were the different types of individuals with alcoholism and different manifestations of problem drinking.[229] Citing the work of leading disease-model scholar E. Morton Jellinek, the plurality suggested that addiction possibly could bar criminal liability if an individual could not stop picking up a drink in the first place or drank to avert withdrawal.[230]

Applying this understanding of addiction to Powell's situation, the plurality took account of the fact that he was capable of stopping after having just one drink, the psychiatrist's testimony that the taking of the initial drink

218. *Id.*
219. *Id.* at 556 (Fortas, J., dissenting).
220. *Id.* at 519 (plurality opinion).
221. *Id.*
222. *Id.* at 520.
223. *Id.* at 521.
224. *Id.* at 517.
225. *Id.*
226. *Id.* at 533.
227. *Id.* at 522.
228. *Id.*
229. *Id.* at 522–23.
230. *Id.* at 525.

is a product of free will, and the fact that Powell was not in a state of withdrawal.[231] The plurality held that the Texas statute did not run afoul of *Robinson* because Powell "was convicted, not for being a chronic alcoholic, but for being in public while drunk on a particular occasion."[232] Put differently, Texas "has not sought to punish a mere status" or a condition but rather "it has imposed upon appellant a criminal sanction for public behavior."[233] The plurality clarified that *Robinson* stands only for the proposition that, in the context of addiction, criminal punishment must apply to an act.[234]

Justice White concurred.[235] Picking up on his dissent in *Robinson*, Justice White declared that "the use of narcotics by an addict must be beyond the reach of the criminal law. Similarly, the chronic alcoholic with an irresistible urge to consume alcohol should not be punishable for drinking or for being drunk."[236] Therefore, if "a showing could be made that resisting drunkenness is impossible *and* that avoiding public places when intoxicated is also impossible," the statute would be unconstitutional, he determined.[237] But here, Justice White concluded that Powell was able to control or manage where he was drinking—even if he could not control his drinking itself: "[Powell] made no showing that he was unable to stay off the streets on the night in question."[238] Moreover, Justice White did not believe that the record supported Powell's contention that Powell was compelled to drink due to an addiction to alcohol.[239] Accordingly, Justice White voted to affirm Powell's conviction.[240]

Four Justices dissented.[241] Their opinion, authored by Justice Fortas, began by noting that under the prevailing disease model "alcoholism is caused and maintained by something other than the moral fault of the alcoholic" and instead is "something that . . . cannot be controlled by him."[242] Justice Fortas interpreted *Robinson* to stand for a principle that "[c]riminal penalties may not be inflicted upon a person for being in a condition he is powerless to

231. *Id.*

232. *Id.* at 532.

233. *Id.*

234. *Id.* at 533. *Powell* therefore overruled any prior, lower federal court rulings inconsistent with this holding, such as *Driver v. Hinnant*, 356 F.2d 761 (4th Cir. 1966). *Cf.* at 764 ("[O]ur excusal of the chronic alcoholic from criminal prosecution is confined exclusively to those acts on his part which are compulsive as symptomatic of the disease. With respect to other behavior—not characteristic of confirmed chronic alcoholism—he would be judged as would any person not so afflicted.").

235. *Id.* at 548–49 (White, J., concurring).

236. *Id.*

237. *Id.* at 551 (emphasis added).

238. *Id.* at 554.

239. *Id.* at 549 n.1.

240. *Id.*

241. *Id.* at 554 (Fortas, J., dissenting).

242. *Id.* at 561.

change."[243] While Robinson "elected to take narcotics," Justice Fortas asserted, "[o]nce Robinson had become an addict, he was utterly powerless to avoid criminal guilt."[244] "He was powerless to choose not to violate the law," he emphasized.[245] Justice Fortas agreed that the statute at issue in *Robinson* punished status, whereas the statute at issue in *Powell* punished conduct.[246] "But the essential constitutional defect here is the same as in *Robinson*, for in both cases the particular defendant was accused of being in a condition which he had no capacity to change or avoid."[247] For Powell, when he took his first drink, he became compelled to drink "to the point of intoxication; and that, once intoxicated, he could not prevent himself from appearing in public places,"[248] the dissent concluded. As intoxication and being intoxicated in public were "characteristic and involuntary" symptoms of alcoholism, Powell could not, under the dissent's theory, be punished for these acts.[249] Accordingly, the dissenting justices would have held that the Texas statute as applied to Powell constituted cruel and unusual punishment.[250]

C. *Two Models*

Robinson and *Powell* have produced two competing interpretations as to when and whether an individual with an addiction may be held criminally responsible for conduct that is symptomatic of the addiction. The analytical distinction between the two is highlighted in *Manning v. Caldwell*,[251] a 2019 case in which the Fourth Circuit split in a deeply divided 8–7 en banc opinion.[252] This section therefore draws upon this recent decision to help illuminate the difference between the two camps.

1. The Status-Conduct Distinction

The traditional reading of the *Robinson-Powell* guideposts is that the government may impose criminal punishment on an individual for their alcohol- or drug-related conduct, but not for their status as an individual with an addiction. Under this bright-line reading, the flaw in the California statute at issue in *Robinson* was that the statute lacked any actus reus, or evil act, a cornerstone of Anglo-American criminal law. As the statute in *Powell*

243. *Id.* at 567.
244. *Id.*
245. *Id.*
246. *Id.*
247. *Id.* at 567–68.
248. *Id.* at 568.
249. *Id.* at 559 n.2.
250. *Id.* at 569–70.
251. 930 F.3d 264 (4th Cir. 2019) (en banc).
252. *Id.* at 286.

contained an actus reus, this argument goes, the statute did not run afoul of the Eighth Amendment as interpreted in *Robinson*.

Most federal circuits have adopted this straightforward status-conduct distinction. The First Circuit put it flatly: "Proof that one acts due to addiction . . . is not proof that one acts involuntarily."[253] The Second Circuit wrote that "[a]n addict who commits an affirmative illegal act, as distinguished from one whose only anti-social behavior is the mere presence of his addiction, may be constitutionally punished."[254] The Fifth Circuit similarly observed that "mere alcoholism does not constitute a mental disease or defect" excusing one from criminal responsibility.[255] Along the same lines, the Eighth Circuit interpreted *Powell* to "h[o]ld that chronic alcoholics could properly be required to control their actions to the extent necessary to avoid collision with the criminal law . . . ."[256] For its part, the Eleventh Circuit noted, "The considerations that make any incarceration unconstitutional when a statute punishes a defendant for his status are not applicable when the government seeks to punish a person's actions,"[257] adding in a subsequent case that the statute at issue in *Powell* was "constitutionally permissible because it punishe[d] an act, 'being in public while drunk on a particular occasion,' not a status, 'being a chronic alcoholic.'"[258] In a case producing a set of extensive opinions, the D.C. Circuit characterized *Robinson* and *Powell* as holding that the Eighth Amendment prohibits the criminal law from punishing the mere craving for alcohol but enables states to prohibit "the acts which give in to that craving," as such acts are not the product of "irresistible compulsion, or [the] loss of self-control."[259]

2. The Categorical-Involuntary Model

In *Manning*, the Fourth Circuit broke with its sister courts in declining to follow the status-conduct distinction of *Robinson* and *Powell*.[260] The case arose out of a Virginia statute that criminalized the use or possession of alcohol by anyone who has a prior intoxication offense or who "has shown

253. United States v. Lopez-Ortiz, 875 F.3d 49, 54 (1st Cir. 2017) (citing *Powell*, 392 U.S. at 535).

254. Smith v. Follette, 445 F.2d 955, 961 (2d Cir. 1971).

255. United States v. Lyons, 731 F.2d 243, 245 n.3 (5th Cir. 1984) (citing *Powell*, 392 U.S. at 535).

256. United States v. Lame, 716 F.2d 515, 521 (8th Cir. 1983) (citing Powell v. Texas, 392 U.S. 514, 535 (1968) (plurality opinion)).

257. United States v. Benefield, 889 F.2d 1061, 1064 (11th Cir. 1989).

258. Joel v. City of Orlando, 232 F.3d 1353, 1362 (11th Cir. 2000) (quoting Powell v. Texas, 392 U.S. 514, 532 (1968) (plurality opinion)).

259. United States v. Moore, 486 F.2d 1139, 1150 (D.C. Cir. 1973).

260. Manning v. Caldwell, 930 F.3d 264, 285–86 (4th Cir. 2019) (en banc).

himself to be an habitual drunkard."[261] The challengers, homeless individuals who claimed to have an addiction to alcohol, contended that "they face an irresistible compulsion to drink and to get drunk in public."[262] The government-defendants moved to dismiss the complaint, which the district court granted.[263] A panel of the Fourth Circuit affirmed, pointing out that "[t]here was no majority holding [in *Powell*] that nonvolitional conduct could invariably be criminalized" and that Justice White's decisive concurrence in *Powell* left open the question of whether behavioral compulsion can negate criminal responsibility.[264] The panel echoed and affirmed the status-conduct distinction, noting that "although states may not criminalize status, they may criminalize actual behavior even when the individual alleges that addiction created a strong urge to engage in a particular act."[265] The panel therefore rejected the constitutional challenge.[266]

The full Fourth Circuit reheard the case[267] and reversed by an 8–7 vote.[268] The en banc majority asserted that, in *Powell*, Justice White "expressly rejected the act-status rationale adopted by the plurality . . . ."[269] According to the majority, Justice White "voted to affirm Powell's conviction *not* because of the act-status theory relied on by the [*Powell*] plurality, but *solely* because Powell had not produced facts establishing the involuntariness of his public alcoholism."[270] The majority concluded that Justice White's involuntary-voluntary distinction was shared by the four dissenting Justices in *Powell*, and thus is the operative standard to assess the constitutionality of criminal statutes applying to individuals with an addiction.[271] Here, the majority held that Virginia could not criminalize behavior that is symptomatic of an illness,

261. Manning v. Caldwell, 900 F.3d 139, 143 (4th Cir. 2018) (citing VA. CODE ANN. § 4.1-333(A) (1993) (amended 2020)), *reh'g granted*, 741 F. App'x 937 (2018) (mem.), *vacated*, 930 F.3d 264 (2019).

262. Hendrick v. Caldwell, 232 F. Supp. 3d 868, 876–77 (W.D. Va. 2017) (quoting Powell v. Texas, 392 U.S. 514, 535 (1968) (plurality opinion)), *vacated sub nom.*, Manning v. Caldwell, 930 F.3d 264 (2019).

263. *Id.* at 895.

264. *Manning*, 900 F.3d at 146–47.

265. *Id.*

266. *Id.* at 153. Following *Manning*, the *Harvard Law Review* published a comment, arguing that, "[p]unishing a homeless alcoholic for *consuming* alcohol is the same as punishing an alcoholic for *being* an alcoholic because, by definition, alcoholics cannot control their alcohol intake unless they are in recovery or recovered." Recent Cases, *Plurality Decisions — The* Marks *Rule — Fourth Circuit Declines To Apply Justice White's Concurrence in* Powell v. Texas *as Binding Precedent*. — Manning v. Caldwell, 900 F.3d 139 (4th Cir. 2018), 132 HARV. L. REV. 1089, 1095 (2019) (emphasis added).

267. Manning v. Caldwell, 741 F. App'x 937 (4th Cir. 2018) (mem.).

268. Manning v. Caldwell, 930 F.3d 264, 286 (4th Cir. 2019) (en banc).

269. *Id.* at 280 (citing Powell v. Texas, 392 U.S. 514, 548–49 (1968) (White, J., concurring)).

270. *Id.* at 282 (citing Powell v. Texas, 392 U.S. 514, 549 n.1 (1968) (White, J., concurring)) (emphasis in original).

271. *Id.* at 280.

where the underlying behavior is otherwise legal.[272] As the case rose to the appeals court on a motion to dismiss, the majority accepted the plaintiffs' bare allegations—that drinking is compelled by their addiction to alcohol—as true.[273]

The opinion provoked a stinging dissent authored by Judge Wilkinson and joined by five of his colleagues.[274] Judge Wilkinson, reflecting the status-conduct distinction, asserted that "the criminal law cannot punish who you are; it can only punish what you do."[275] Accordingly, "although states may not criminalize status, they may criminalize actual behavior even when the individual alleges that addiction created a strong urge to engage in a particular act," he explained.[276]

Judge Wilkinson acknowledged that in his *Powell* concurrence Justice White questioned "whether conduct compelled by addiction might be protected under *Robinson*."[277] But the dissent observed that Justice White sided with the plurality because "Powell's behavior involved a volitional act," specifically whether he was in public.[278] The dissent noted therefore that Justice White "chose to resolve the case without reaching the broader question of compulsion," leaving *Robinson*'s status-conduct distinction "undisturbed."[279] Judge Wilkinson emphasized that "Justice White concurred in this judgment because the statute in question involved an act that was clearly volitional, forestalling the need to examine whether and under what conditions nonvolitional conduct might be constitutionally shielded from criminal sanctions."[280] Any speculation from Justice White about whether criminal law can reach compelled conduct constitutes mere dicta, the dissent concluded.[281]

The dissent further argued that the compelled-conduct exception to criminal law limitation is not only unsupported, but is also unworkable;[282] there is no reliable standard to assess which conduct is compelled and therefore placed outside of the bounds of the criminal law.[283] The majority's

272. *Id.* at 285; *see also id.* ("In sum, we hold that the challenged Virginia statutory scheme is unconstitutionally vague, and that even assuming it could be limited to those suffering from alcoholism, Plaintiffs have stated an Eighth Amendment claim under both *Robinson* and *Powell*.").

273. *Id.* at 282.

274. *Id.* at 286 (Wilkinson, J., dissenting). Judge Diaz filed a separate dissenting opinion, *id.* at 306 (Diaz, J., dissenting), bringing the total number of dissenting judges to seven.

275. *Id.* at 288 (Wilkinson, J., dissenting); *see also id.* at 292 ("[T]here must be some behavioral link set forth in the law.").

276. *Id.* at 290–91.

277. *Id.* at 289.

278. *Id.*

279. *Id.*; *see also id.* at 290 ("[T]he *Powell* decision does not overturn or in any way disrupt *Robinson*.").

280. *Id.* at 290.

281. *Id.* at 291.

282. *Id.* at 286–87.

283. *Id.* at 291.

limiting principle of confining its rule to otherwise lawful conduct, the dissent suggested, is inconsistent with the criminal law's traditional acceptance of legislatures barring certain classes of people, such as recidivists, from engaging in specific behavior that others can.[284]

The Ninth Circuit also appears to have moved away from the status-conduct camp. For years, and on a repeated basis, the Ninth Circuit followed the status-conduct approach. In one case, that court held that, under *Robinson*, it is unconstitutional to "criminalize[] the status of being addicted to narcotics," and that *Powell* "subsequently limited the applicability of *Robinson* to crimes that do not involve an actus reus . . . ."[285] In another, the court rejected a challenge to the application of a criminal statute, reasoning that the defendant "is not being punished because he has [certain] status," but rather "he is being punished for having committed the [proscribed] act . . . ."[286] In a third, the court refused to accept a defendant's generous construction of *Powell*, explaining with reference to *Powell* that the defendant's "conduct rather than his status as an alcoholic led to his confinement."[287] Shortly after *Powell*, the court concluded that, even if there was evidence that the defendant "was a chronic alcoholic in the sense that he could not prevent himself from drinking," he would not be "excused . . . from criminal responsibility under the present state of the law."[288]

In 2006, the Ninth Circuit started showing signs of breaking from the prevailing status-conduct interpretation of *Robinson* and *Powell* when the court reviewed a challenge, brought by homeless individuals who could not obtain shelter, against a Los Angeles ordinance that criminalized the sitting, lying, or sleeping on public streets or sidewalks within city limits.[289] The court invalidated the ordinance, holding, as the en banc Fourth Circuit did, that Justice White's concurring opinion in *Powell* and the opinion of four dissenting Justices together "stand for the proposition that the Eighth Amendment prohibits the state from punishing an involuntary act or condition if it is the unavoidable consequence of one's status or being."[290] The opinion was later vacated, however, when the parties to the action settled.[291]

284. *Id.* at 296.

285. United States v. Ayala, 35 F.3d 423, 425–26 (9th Cir. 1994) (citing Powell v. Texas, 392 U.S. 514, 533 (1968) (plurality opinion)).

286. United States v. Parga-Rosas, 238 F.3d 1209, 1212 (9th Cir. 2001).

287. Halvorsen v. Baird, 146 F.3d 680, 687 (9th Cir. 1998) (citing Powell v. Texas, 392 U.S. 514, 532 (1968) (plurality opinion)).

288. Kane v. United States, 399 F.2d 730, 736 n.9 (9th Cir. 1968) (citing Powell v. Texas, 392 U.S. 514, 514 (1968) (plurality opinion)).

289. Jones v. City of Los Angeles, 444 F.3d 1118, 1138 (9th Cir. 2006).

290. *Id.* at 1135.

291. Jones v. City of Los Angeles, 505 F.3d 1006, 1006 (9th Cir. 2007).

In a similar case, the Ninth Circuit in 2018 considered a challenge, brought by homeless individuals unable to obtain shelter, to the constitutionality of a Boise ordinance that criminalized sleeping outside in public within city limits.[292] The court stated that, though it was not bound by the vacated 2006 opinion, it nonetheless was persuaded by its reasoning.[293] Applying the standard cobbled together from the *Powell* concurring and dissenting opinions, the Ninth Circuit determined that sleeping in public was an unavoidable consequence of the defendants' status as homeless individuals, as the city had run out of beds for the homeless, and thus homeless individuals had no option but to sleep outside.[294]

The case was referred for possible en banc review and in 2019 the full court declined to rehear the case.[295] But six judges dissented from the denial of en banc review, indicating a strong disagreement with the panel opinion's apparent departure from the status-conduct distinction.[296] Judge Smith, writing for the six dissenting judges, expressly charged that the panel misinterpreted *Powell*.[297] The appropriate way to apply *Powell*, he argued, was not to combine the concurrence and dissent into a quasi-holding, but to identify the narrow, substantive overlap between the concurrence and plurality opinions.[298] The *Powell* concurrence and plurality agreed, the dissent argued, that Powell's "conviction was constitutional because it involved the commission of an act. Nothing more, nothing less."[299] As the dissent could not convince enough judges to revisit the panel opinion, the pathbreaking approach adopted by the panel opinion remains the law of the circuit.

The Ninth Circuit's approach may signal a deeper split among the federal circuits on the meaning of *Robinson* and *Powell*, and specifically whether and when conduct may be deemed involuntary for purposes of criminal law. While the Ninth Circuit's interpretations of *Robinson* and *Powell* arise in the context of homelessness, not addiction, its reasoning applies to the addiction context, and there is no basis to suspect that the rationale adopted by the Circuit is limited to matters of homelessness.

* * *

Courts and scholars agree that *Robinson* prohibits the government from imposing criminal liability on an individual for having the status of an

292. Martin v. City of Boise, 902 F.3d 1031, 1035 (9th Cir. 2018), *aff'd in part*, *rev'd in part*, 920 F.3d 584 (2019).

293. *Id.*

294. *Id.* at 1048.

295. Martin v. City of Boise, 920 F.3d 584, 588 (9th Cir. 2019).

296. *Id.* at 590 (Smith, J., dissenting).

297. *Id.*

298. *Id.* at 591.

299. *Id.*

individual with drug or alcohol disease. Accordingly, being an individual with drug or alcohol disease or having the condition of addiction cannot be the basis, by itself, for the imposition of criminal liability. The unanimity stops there. Most circuits hold that, under *Powell*, no constitutional issue arises from the imposition of criminal punishment for an actus reus, such as being intoxicated, even if the actus reus is symptomatic of an addiction, such as an addiction to alcohol.[300] But under the emerging minority view—championed by the Fourth Circuit and joined perhaps by the Ninth—*Powell* stands for the principle that an action compelled by addiction is not voluntary and criminal liability predicated on that compelled action is thus inappropriate. In the next part, I argue that both models are flawed, and I propose an alternative that is more legally and clinically sound.

III. AN INDIVIDUALIZED, EMPIRICAL MODEL

This part argues that the two competing interpretations of *Powell*—the majority view that an individual with an addiction can be punished for conduct and the emerging view that an individual with drug or alcohol disease cannot be punished for nonvolitional conduct—are both wrong. First, Justice White voted to uphold Powell's conviction because the statute applied to volitional conduct and because Powell could not show that his conduct was not volitional. The status-conduct approach, asking only whether a statute criminalizes conduct irrespective of its volitional character, therefore is wrong because it focuses only on the presence of an actus reus and denies the individual the opportunity to make a particularized showing that criminal liability is not appropriate. Second, while the Fourth Circuit adopted the correct understanding of Justice White's concurring opinion, it mistakenly treated all individuals with an addiction as categorically immune from criminal responsibility. As Justice White's opinion and addiction-related sources such as medical studies, twelve-step literature, addiction treatment programs, and drug court programs indicate, an individual with an addiction to drugs or alcohol can exercise choice as to whether to address the addiction. Therefore, courts should probe whether, according to the facts—not merely the label of addiction—the individual with an addiction could exercise that choice. The Fourth Circuit did not examine these individualized conditions, looking instead to the diagnosis alone as a shield to criminal liability.

This part therefore argues in favor of a third, evidentiary model in which an individual with an addiction must prove that addressing the addiction was

300. United States v. Moore, 486 F.2d 1139, 1151 (D.C. Cir. 1973) (holding that an addiction defense under *Powell* would result in a "multitude of acts which are now crimes" being "excused if [such] defense w[as] accepted"); Manning v. Caldwell, 930 F.3d 264, 289–90 (Wilkinson, J., dissenting) (collecting cases holding that punishment for unlawful conduct resulting from drug and alcohol disease is not unconstitutional).

not possible and therefore lacks the culpability or blameworthiness necessary for criminal liability to attach. It outlines what this showing would entail and further explains that this showing is a difficult one. As such, the defense to liability is commensurately narrow.

A. *Conduct and Choice*

The Marks *Rule*. The general response to the question of whether and when an individual with an addiction may be held criminally responsible for acts symptomatic of the addiction boils down to a more specific question: How should courts properly interpret the fractured plurality opinion in *Powell*? It appears undisputed that Justice White's opinion is controlling. The dispute instead centers on the precedential standard to be extracted from that opinion. The courts are right to look to Justice White's concurring opinion; the Supreme Court's *Marks v. United States*[301] rule instructs courts, in the event of a plurality opinion, to give effect to the concurring opinion's overlap with the plurality opinion.[302] The Supreme Court's ruling in *University of California Regents v. Bakke*[303]—concerning the constitutionality of race-conscious admissions—offers a helpful example of the application of the *Marks* principle. In *Bakke*, the Court issued a plurality opinion.[304] Justice Powell's concurring opinion, which supplied the fifth vote for the judgment, is understood to be the controlling opinion in the case.[305] Whereas the plurality found four compelling state interests to justify the admissions system at issue, Justice Powell accepted only one such reason; it is only that one reason that has any precedential value moving forward because it is the only overlap between the plurality and the concurring opinion.[306]

Here, most circuits are incorrect to interpret Justice White's concurrence in *Powell* as the basis for a binding status-conduct distinction. It is true that the plurality in *Powell* strictly followed *Robinson*'s status-conduct distinction and therefore asked only whether the statute criminalized Powell for being an individual with drug or alcohol disease (status) *or* whether it criminalized an actus reus (conduct).[307] The statute contained two actions—1) being drunk and

301. 430 U.S. 188 (1977).

302. *See id.* at 193 ("When a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgment on the narrowest grounds . . . .'" (quoting Gregg v. Georgia, 428 U.S. 153, 169 n. 15 (1976) (plurality opinion))).

303. 438 U.S. 265 (1978).

304. *Id.* at 267–68.

305. *See* Grutter v. Bollinger, 288 F.3d 732, 741 (6th Cir. 2002) (en banc), *aff'd*, 539 U.S. 306 (2003).

306. *See id.*

307. *See* Powell v. Texas, 392 U.S. 514, 532 (1968) (plurality opinion).

2) being drunk outside—and for the plurality, the existence of an actus reus was sufficient to distinguish Powell's case from *Robinson*.[308]

If Justice White agreed with the status-conduct distinction, he would have upgraded the 4–1–4 plurality into a 5–4 majority.[309] But Justice White's exploration of whether Powell had shown that he was unable to control these two actions demonstrates that he was not only concerned with whether Powell had committed an identifiable actus reus. Rather, his opinion and vote to uphold the constitutionality of the conviction hinged entirely on the absence of this showing. Indeed, it was dispositive to Justice White that Powell failed to prove that he had no choice to be outside.[310] This reading of Justice White's opinion is also faithful to his dissent in *Robinson*. There, Justice White suggested that his vote may have changed if Robinson "was convicted for being an addict who had lost his power of self-control . . . ."[311]

Justice White indicated that the other relevant conduct, being drunk, could be involuntary too.[312] This speculation about compelled use itself may be set aside as dicta.[313] But the importance of the voluntary nature of Powell's *location* to Justice White's opinion demonstrates that Justice White looked deeper than the status-conduct distinction to ensure specifically that the criminalized conduct was voluntary. Under *Marks*, Justice White's voluntariness requirement serves as the narrowest grounds, and thus the controlling standard, because it restricts the universe of what may be criminalized from any conduct (plurality view) to voluntary conduct (concurring view),[314] much in the same way that Justice Powell's concurring opinion in *Bakke* limited the universe of acceptable reasons for affirmative action from four to one.[315]

Importance of Voluntariness. As a matter of first principles, insisting that an individual's conduct is voluntary prior to the imposition of criminal penalties is most sensible. It is a basic assumption of criminal law that

308. *See id.*

309. Subsequent Supreme Court decisions confirm that *Robinson* was limited to prohibiting the imposition of criminal punishment for having an addiction to the use of drugs and does not extend to the statutes concerning the use itself. *See, e.g.*, Atkins v. Virginia, 536 U.S. 304, 311 (2002) (interpreting *Robinson* as holding that punishment "may not be imposed as a penalty for 'the "status" of narcotic addiction'"); Solem v. Helm, 463 U.S. 277, 287 (1983) (stating that *Robinson* invalidated "the crime of *being 'addicted* to the use of narcotics'"(quoting Robinson v. California, 370 U.S. 660, 665 (1962)) (emphasis added)); Rummel v. Estelle, 445 U.S. 263, 268 (1980) (noting that *Robinson* invalidated the "statute making it a crime to *be addicted* to the use of narcotics" (emphasis added)).

310. *Powell*, 392 U.S. at 554 (White, J., concurring).

311. Robinson v. California, 370 U.S. 660, 685 (White, J., dissenting).

312. *Powell*, 392 U.S. at 549 (White, J., concurring).

313. *See* Manning v. Caldwell, 930 F.3d 264, 290 (4th Cir. 2019) (en banc) (Wilkinson, J., dissenting).

314. *See supra* note 302 and accompanying text.

315. Regents of Univ. of Cal. v. Bakke, 438 U.S. 265, 299–300 (1978).

individuals possess the capacity both to understand the limits on conduct established by law and to conform their conduct accordingly.[316] Criminal liability, therefore, is predicated on the choice by the individual to step beyond the boundaries of lawful conduct; without such choice, the individual is not suited to criminal punishment. Justice White's approach—contemplating the possibility that the conduct of the individual with drug or alcohol disease is not truly voluntary—pays tribute to the foundational requirement that criminal liability follows individual agency.

Therefore, the majority view is wrong to ask only whether criminal punishment attaches to an actus reus. Instead, the courts should ensure that the relevant conduct is voluntary. In this respect, the Fourth and Ninth Circuits are correct to focus on whether the relevant actions are voluntary and not only whether the statute proscribes some cognizable action.

The Evidentiary Approach in Criminal Law. The individualized inquiry contemplated by Justice White is not uncommon in the criminal context. The Seventh Circuit, for example, considered an argument that a defendant "is immune from prosecution [for receiving, distributing, and possessing child pornography] because as a pedophile or ephebophile he is compelled to collect, receive and distribute child pornography."[317] The court did not accept the bald assertion that the defendant's disease rendered the relevant conduct beyond his control. Rather, the court noted that, even if the defendant "is a pedophile and/or ephebophile and . . . his receipt, distribution and possession of child pornography 'was a pathological symptom of [his] pedophilia and/or ephebophilia,'" the defendant "did not show that this charged conduct was involuntary or uncontrollable."[318] The facts proved the opposite; according to psychological reports, the "defendant could control his impulses to access child pornography," irrespective of the claim that he had an associated disease.[319] Thus, there is existing support in the criminal context for the proposition that a disease alone does not determine whether prohibited conduct is voluntary. The dispositive question instead, as reflected in Justice White's concurrence and the Seventh Circuit opinion, is whether the defendant can nonetheless prove that the unlawful conduct is involuntary in light of their individual circumstances.

B. *Addiction and Choice*

For its part, the Fourth Circuit categorically equates the status of addiction with compulsion to drink or use.[320] In doing so, it assumes that all

316. *See supra* note 2 and accompanying text.
317. United States v. Black, 116 F.3d 198, 201 (7th Cir. 1997).
318. *Id.* (alteration in original).
319. *Id.*
320. *See* Manning v. Caldwell, 930 F.3d 264, 281 (4th Cir. 2019) (en banc).

individuals with drug or alcohol disease are categorically incapable of exercising choice as to drinking or using.[321] This assumption is wrong. Medical literature, twelve-step fellowship programs, substance use disorder programs, and drug court programs all support the proposition that an individual with drug or alcohol disease can be capable of choice and thus may be the proper subject of criminal sanction.

As a threshold matter, the involuntary acquisition of a disease, for which the individual lacks any blameworthiness, does not negate the responsibility to exercise choice once the disease is acquired. On the contrary, an individual is blameworthy for failing to fulfill that responsibility. As further explained below, the existence of the disease does not mean that the individual with an addiction lacks awareness of the adverse manifestations of the disease; lacks the opportunity or duty to address the disease; lacks workable options to address the disease; is automatically compelled to drink or use; is categorically compelled to drink or use; or is to be defined by the label of the disease rather than by that awareness, opportunity, viable options, or individual circumstances.

Irrelevance of Involuntary Acquisition. Under the disease model of addiction, the individual is not to blame for having an alcohol or substance use disorder.[322] But the involuntary acquisition of the disease does not render the individual categorically incapable of addressing the disease and its adverse manifestations. As noted by Dr. David Linden, a neurologist at Johns Hopkins University, "The development of an addiction is not the addict's fault"; however, "believing that addiction is a disease does not absolve addicts from responsibility for their own recovery."[323] "It's not a free ride," he added.[324]

Capacity for Conscious Awareness. An individual with alcohol or drug disease can form a conscious awareness that their drinking or use is problematic and therefore warrants a corrective response. Twelve-step fellowship programs note that the individual with an addiction may be conscious of the troubling nature of drinking or using, even while drinking or

321. *See id.*

322. *See* Hanna Pickard, *Responsibility Without Blame for Addiction*, 10 NEUROETHICS 169, 177 (2017) ("According to the disease model, addicts are neither responsible nor to blame; their condition is the result of a disease that has taken hold, and so the negative consequences of drug use are no one's fault . . . .").

323. Mary Carole McCauley, *Johns Hopkins Neuroscientist David Linden Explains the Biology of Pleasure*, BALT. SUN (Apr. 14, 2011, 8:30 AM), https://www.baltimoresun.com/health/bal-defining-addiction-0414-story-story.html [https://perma.cc/CD2H-J5VQ (dark archive)].

324. *Id.*; *see also* Sara Gordon, *About a Revolution: Toward Integrated Treatment in Drug and Mental Health Courts*, 97 N.C. L. REV. 355, 372 (2019) ("[E]ven if we accept that addiction is a disease of the brain, it is still the case that the addicted individual has a significant role to play both in her illness and her recovery.").

using. Indeed, the AA's' "Big Book" references an individual with drug or alcohol disease who reveals, "I was having these little moments of clarity, times I knew for sure that I was an alcoholic. Times when I was looking at the bottom of my glass asking myself, Why am I doing this?"[325] The very first step in the twelve-steps is an admission that the individual's life has become "unmanageable" due to alcohol.[326] This admission necessarily requires an awareness of both the destructive impact of alcohol and the source of that destruction, namely alcohol. The individual's tremendous capacity for guilt and shame further reinforces the individual's capacity for reflection as to the negative consequences of drinking or using.[327]

Drug treatment programs likewise link conscious thought to drinking or using. Take, for instance, the conceptualization of relapse by a well-established treatment facility in the Washington, DC, area, which notes that relapse is preceded by prior thoughts rationalizing the drinking or use, beliefs that drinking or use will be pleasurable, and ultimately permission to drink or use.[328] A federal court similarly reasoned that, even if an individual with addiction lacks control while intoxicated, "such substance abusers are not regarded as deprived of free will for offenses committed during 'lucid' intervals."[329] Unless the individual is in a state of fixed insanity, these intervals serve as opportunities for the individual to reflect and resolve to address the illness.[330]

The Duty to Mitigate. Alcohol and drug use impose significant costs on the individual and society at large. Consider that, in a twelve-month period ending in May of 2020, over 81,000 individuals died of a drug-related overdose.[331] Similarly, the estimated economic impact of the opioid epidemic—including deaths, health care costs, and criminal justice

325. ALCOHOLICS ANONYMOUS, THE BIG BOOK 284 (4th ed. 2001) [hereinafter THE BIG BOOK].

326. *See id.* at 59 ("We admitted we were powerless over alcohol—that our lives had become unmanageable.").

327. *See, e.g.*, Masuma Rahim & Robert Patton, *The Association Between Shame and Substance Use in Young People: A Systematic Review*, PEERJ, Jan. 22, 2015, at 3, 3 ("As [adolescent substance users'] capacity for self-reflection . . . develops, adolescents are more likely to compare themselves negatively to peers . . . .").

328. *Glossary of Terms*, KOLMAC OUTPATIENT RECOVERY, https://www.kolmac.com/understanding-addiction/glossary-of-terms/ [https://perma.cc/WBG8-QZ8V].

329. United States v. Shorter, 618 F. Supp. 255, 261 (D.D.C. 1985).

330. *See also* Morse, *supra* note 179, at 171 ("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. Sick people who behave immorally or who violate the criminal law are almost always responsible agents.").

331. *See* Robin Foster, *U.S. Drug Overdose Deaths Reach Record Highs*, U.S. NEWS & WORLD REP. (Dec. 17, 2020), https://www.usnews.com/news/health-news/articles/2020-12-17/us-drug-overdose-deaths-reach-record-highs [https://perma.cc/XD3U-B99E (dark archive)].

expenditures—is $179 billion in one year.[332] In addition, drunk driving vehicle accidents cause over 10,000 deaths per year in the United States, an average of one death every 50 minutes.[333] These deaths and associated costs, according to the National Highway Transportation Safety Administration, impose a yearly financial cost of $44 billion.[334] The human toll of addiction and overdoses cannot be ignored or understated. Judge Marielsa Bernard, whose daughter died of an overdose, shares: "You go through hell when you have an addicted child because you just never know what's gonna happen—they become someone you don't really know . . . . After they die, you're in hell still, but it's a different kind of hell."[335] As these figures and words indicate, alcohol and drug use can kill individuals, destroy families, and unleash significant personal and financial costs on society.

Conscious awareness of alcohol and drug use permits awareness of the consequences—both actual and potential—of that use. An individual who is consciously aware of their alcohol or drug use has an affirmative moral and social duty to address those consequences. In the very first step in the twelve steps of AA, the individual admits that they alone are "powerless" over alcohol.[336] Though the individual by themselves is powerless as to alcohol, AA explains that the individual is "*not* powerless over assuming responsibility for [her] own recovery."[337]

332. *See* Selena Simmons-Duffin, *The Real Cost of the Opioid Epidemic: An Estimated $179 Billon in Just 1 Year*, NAT'L PUB. RADIO (Oct. 24, 2019, 4:25 PM), https://www.npr.org/sections/health-shots/2019/10/24/773148861/calculating-the-real-costs-of-the-opioid-epidemic [https://perma.cc/P3YK-N7DN].

333. *Drunk Driving*, NAT'L HIGHWAY. TRANSP. SAFETY ADMIN., https://www.nhtsa.gov/risky-driving/drunk-driving [https://perma.cc/7YL5-A62W].

334. *Id.*

335. Cindy Rich, *A Mother's Heartbreak: Heroin's Toll in Montgomery County*, BETHESDA MAG. (Nov. 2, 2015, 1:50 PM), https://bethesdamagazine.com/bethesda-magazine/november-december-2015/a-mothers-heartbreak-heroins-toll-in-montgomery-county/ [https://perma.cc/QAQ2-P6P9 (dark archive)]. There are countless accounts of families coping with the grief of losing a loved one and of supporting one another following a loss.

336. THE BIG BOOK, *supra* note 325, at 59. The notion that the individual is unable to extricate themselves from the grips of addiction is found in perhaps the earliest reference to addiction in the United States. In 1778, Anthony Benezet wrote, "The unhappy dram-drinkers are [s]o ab[s]olutely bound in [s]lavery to the[s]e infernal [s]pirits, that they [s]eem to have lo[s]t the power of *delivering them[s]elves* from this wor[s]t of bondage." Anthony Benezet, *Remarks on the Nature and Bad Effects of Spirituous Liquors*, *in* SERIOUS CONSIDERATIONS ON SEVERAL IMPORTANT SUBJECTS 40, 42 (1778) (emphasis added).

337. DAILY REFLECTIONS, *supra* note 121, at Jan. 3. That said, an emerging alternative fellowship program, SMART Recovery, expressly disagrees that the individual is personally powerless to effectuate change in respect to their drug of choice. *Compare About SMART Recovery*, SMART RECOVERY (2019), https://www.smartrecovery.org/about-us/ [https://perma.cc/4RQ8-P6QY] ("You may believe, for example, that you're powerless, or that after the first drink you lose all control and can't stop. These beliefs may actually be damaging to you."), *with* THE BIG BOOK, *supra* note 325, at 24 ("The fact is that most alcoholics . . . have lost the power of choice in drink." (emphasis omitted)). SMART Recovery instead seeks to support the individual's ability to change

For an individual with an addiction to avert this responsibility because their addiction is a disease or was involuntarily acquired would be to shift the costs of the action away from the individual and onto society; thus, an individual would be free to leave a disease unaddressed. We would not want an individual in active addiction to hurt themselves or others any more than we would want an individual with poor eyesight to walk around without glasses or contacts and wander into traffic, or worse. The disability context is instructive: if an individual does not take such responsive efforts, "it is wholly proper to say that [their] disability flows, not from the disease or injury itself" but from the "voluntary failure or refusal to take the available corrective or ameliorative action."[338] Similarly, there is no reason to exempt an individual with drug or alcohol disease wholesale from the responsibility to offset the problematic manifestations of the addiction. Leading criminal law theorist Sanford Kadish explained that the disease of addiction does not negate that responsibility:

> To find that criminal conduct is causally related to persistent patterns of behavior which are to some extent medically treatable (for this is what sickness here presumably connotes) does not establish that punishment is unjust. Being 'sick' in this sense does not mean or imply that the person is irresponsible and not morally culpable. Just as a psychiatric diagnosis of mental illness does not itself establish a defense of legal insanity, neither does a diagnosis of addiction establish that the addict is not responsible for his actions.[339]

Fulfilling the Duty To Mitigate. Individuals with addiction to drugs or alcohol can and do take action to convert the conscious desire to address the disease into "efforts" to address the disease.[340] Those efforts include seeking and obtaining treatment. "Research shows that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives."[341] The corrective efforts can also include participation in fellowship programs.[342] According to one report, over one million Americans are part of

her thoughts, and thus their habits. *See About SMART Recovery*, *supra* ("In SMART we focus on learning coping skills that work well short- and long-term."); Peter Soderman, *What We Can Learn, We Can Unlearn*, SMART RECOVERY, https://www.smartrecovery.org/what-we-can-learn-we-can-unlearn-1/ [https://perma.cc/FAF6-7YA6] ("Your brain is constantly changing, and you have ultimate control over it—for good or ill.").

338. Baker v. Off. of Pers. Mgmt., 782 F.2d 993, 994 (Fed. Cir. 1986).

339. Sanford H. Kadish, *Excusing Crime*, 75 CALIF. L. REV. 257, 286 (1987).

340. DSM-5, *supra* note 133, at 490.

341. *What Is a Substance Use Disorder?*, AM. PSYCHIATRIC ASS'N (Dec. 2020), https://www.psychiatry.org/patients-families/addiction/what-is-addiction [https://perma.cc/T7TT-MSQ4].

342. *Drugs, Brains, and Behavior*, *supra* note 80, at 25. Twelve-step programs tout themselves as the most reliable means by which to eliminate the adverse impact of addiction and to achieve a life of sobriety, health, and freedom. *See* THE BIG BOOK, *supra* note 325, at 58; *Effectiveness of 12 Step Programs*, BURNING TREE (2019), https://www.burningtree.com/effectiveness-12-step-programs/

AA,[343] each person serving as proof that those with the disease can and do respond to the disease. This approach can be effective. Indeed, a little-known fact is that the original name for the AA text was "The Way Out,"[344] reflecting fellowship-based recovery as a viable means of transitioning from active addiction to sobriety.[345]

Distinguishing Between Addiction and Involuntariness. That individuals with alcohol or drug disease may be aware of their actions and that there are viable options to address the disease cut against the notion that individual drinking or using automatically or categorically rises to the level of a cognizable compulsion. Professors Richard Holton and Kent Berridge write that "the brain of an addict is importantly different from that of a normal nonaddicted individual" and that "once addiction is under way, the desire for the addictive drug takes on a life of its own, with an intensity that is particularly, perhaps uniquely, high."[346] But this fact, they point out, should not be equated with involuntary conduct: "[T]he intensity and power of addictive desires do[es] not mean that addicts are automata, standing powerless spectators as they are moved by their desires."[347]

The traditional bar for involuntariness is particularly high. Indeed, in ordinary criminal law, involuntariness exists where the actus reus is a reflexive or conditioned response to external stimuli.[348] A classic illustration of involuntariness is the war veteran who responds unconsciously to stressful situations.[349] What sets these instances of involuntariness apart from the

[https://perma.cc/BD9P-CP55] ("Research shows that that most effective plan is one that includes a treatment program followed by participation in Alcoholics Anonymous (AA) . . . ."); Michael Miller, *The Relevance of Twelve-Step Recovery in 21st Century Addiction Medicine*, AM. SOC'Y OF ADDICTION MED. (Feb. 13, 2015), https://www.asam.org/resources/publications/magazine/read/article/2015/02/13/the-relevance-of-twelve-step-recovery-in-21st-century-addiction-medicine [https://perma.cc/XD4P-47LL] ("Twelve Step Facilitation therapy is still a tried-and-true proven approach. It is far more than advising a patient to 'go to AA' and providing them a list of meeting locations and times.").

343. Katy Steinmetz, *AA Around the World*, TIME (Jul. 2, 2010), http://content.time.com/time/specials/packages/article/0,28804,2001284_2001057_2001044,00.html [https://perma.cc/V59W-HEZL].

344. *See* DAILY REFLECTIONS, *supra* note 121, at Nov. 25 (explaining that the original title was discarded once it was discovered that books with similar titles were on the market).

345. *See* THE BIG BOOK, *supra* note 325, at 58 ("Rarely have we seen a person fail who has thoroughly followed our path.").

346. Richard Holton & Kent Berridge, *Addiction Between Compulsion and Choice*, *in* ADDICTION AND SELF-CONTROL: PERSPECTIVES FROM PHILOSOPHY, PSYCHOLOGY, AND NEUROSCIENCE 239, 241 (Neil Levy ed., 2013).

347. *Id.* at 242.

348. LAFAVE, *supra* note 171, § 9.4.

349. *See, e.g.*, State v. Perkins, 538 P.2d 829, 833 (Wash. Ct. App. 1975) ("On the witness stand Mr. Perkins recalled all of the incidents which led up to the shooting . . . but 'then everything went black.' His next recollection is walking to a vehicle accompanied by a deputy sheriff."); State v. Utter, 479 P.2d 946, 947–48 (Wash. Ct. App. 1971) ("Conditioned response was defined by [a

addiction context is that the former do not involve conscious awareness of the conduct: the body responds while the individual is unconscious or before there is any deliberation or opportunity to deliberate.[350] For the individual with drug or alcohol disease, by contrast, the underlying conduct may be appreciated.[351] Consistent with this general understanding and the concept of lucid intervals, Professor Kadish explained:

> [T]he characteristic actions of an addict could hardly be made to fit [the meaning of an involuntary act]. They are movements he chooses to make to achieve his purposes and therefore have nothing in common with falling or being pushed or with reflexive or convulsive movements, or even with sleepwalking or hypnotic movements. There is a substantial difference between those movements and the complex and varied activities involved in obtaining and using alcohol and other drugs. There are enough conscious, purposive actions in the characteristic behavior of addicts (including abstinence when the motivation is great enough) that it cannot possibly be considered involuntary.[352]

Because conduct that is symptomatic of the addiction can be voluntary, it may be properly punished. Take for example drug courts, generally specialized courts that promote treatment of defendants charged with nonviolent conduct that stems from their drinking or use.[353] In drug court, jail is a common sanction for a program participant who relapses while in the program. The National Drug Court Institute notes that "Drug Courts typically administer a gradually escalating sequence of consequences for substance use. The earliest consequences often involve enhancing treatment services, whereas later consequences may include punitive sanctions of increasing severity."[354] Some

psychiatrist at trial] as 'an act or a pattern of activity occurring so rapidly, so uniformly as to be automatic in response to certain stimulus.' [Appellant] testified that as a result of his jungle warfare training and experiences in World War II, he had on two occasions in the 1950's reacted violently towards people approaching him unexpectedly from the rear.").

350. *See* LAFAVE, *supra* note 171, § 6.1(c) (defining a voluntary act as one in which the "mind has quickly grasped the situation and dictated some action").

351. *See supra* notes 325–30 and accompanying text.

352. Kadish, *supra* note 339, at 286–87.

353. *See* U.S. SENT'G COMM'N, FEDERAL ALTERNATIVE-TO-INCARCERATION COURT PROGRAMS 5 (2017), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20170928_alternatives.pdf [https://perma.cc/9D3B-9A3K].

354. DOUGLAS B. MARLOWE, NAT'L DRUG CT. INST., BEHAVIOR MODIFICATION 101 FOR DRUG COURTS: MAKING THE MOST OF INCENTIVES AND SANCTIONS 5 (2012); *see also* RYAN S. KING & JILL PASQARELLA, THE SENT'G PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 4 (2009) ("A participant who is non-compliant with any of the drug court protocols can be sanctioned through a variety of means, including increased status hearings, drug tests or jail time. . . . [F]or persons who have violated the terms of their drug court sentence by relapsing, . . . a judge can . . . impos[e] some type of sanction, including a brief period of incarceration."); *cf*. Mike Riggs, *Want To Go to Drug Court? Say Goodbye to Your Rights: Why the Bipartisan Push for Drug Courts Is Overrated*,

drug courts adopt this approach of reserving jail for multiple positive urinalysis results,[355] while others may send a participant to jail even for the first positive urine test.[356]

Ostensibly, these sanctions are premised on the principle that the individual can conform their conduct to the behavioral requirements of the drug court program, including abstinence from alcohol and drugs. The failure to adhere to these requirements thus may be met with punitive consequences—even though the program participant has an addiction to drugs and/or alcohol. It is unclear why individuals with drug or alcohol disease may be held responsible for their actions and deemed appropriate subjects of punishment in the specialized drug court context but not in the criminal justice system overall.

Addiction Cannot Be Categorically Examined. How an individual with an addiction can effectively address their addiction depends on the nature and circumstances of the individual. As the National Institute on Drug Abuse notes, "[n]o single treatment is appropriate for everyone."[357] Treatment programs and twelve-step fellowship programs likewise stress that no person's treatment or recovery will be identical.[358]

The disability context similarly emphasizes the need to appraise the specific situation facing the individual when making a disability determination. Consider a debate that arose between two circuits as to whether an individual who achieves good grades nonetheless can be an individual with a learning disability. On one hand, the Second Circuit held that the relevant question in determining whether a student has a cognizable

REASON (Aug. 17, 2012, 10:30 AM), https://reason.com/2012/08/17/want-to-go-to-drug-court-say-goodbye-to/ [https://perma.cc/SWB5-597J] ("In every [drug] court that receives federal funding, jail is a mandatory penalty.").

355. *E.g.*, PALM BEACH CNTY. DRUG CT. OFF., DRUG COURT TABLE OF SANCTIONS (assigning a twenty-four-hour jail sanction to a second positive urinalysis result).

356. *E.g.*, BLUE EARTH CNTY. ADULT HYBRID DRUG CT., PARTICIPANT HANDBOOK 24 ("If you have a positive test in any drug court phase, the judge, based on recommendations from the drug court team, will apply immediate sanctions including time in jail to help you stop your drug using behavior."); MONTGOMERY CNTY. ADULT DRUG CT. INTERVENTION TRACK, PARTICIPANT HANDBOOK 33 (including jail time in the various sanctions available to courts after a single positive urinalysis result).

357. *Principles of Drug Addiction*, *supra* note 108, at 4; *see also id.* ("Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.").

358. *See, e.g.*, THE BIG BOOK, *supra* note 325, at xxv (2009) ("I personally know scores of cases who were of the type with whom other methods had failed completely."); *Our Treatment Philosophy*, CARON, https://www.caron.org/proven-treatment/treatment-philosophy [https://perma.cc/XP95-V8AY] ("We tailor clinically proven addiction treatment plans to each patient and family member."); *Where Can I Get the Best Addiction Treatment Programs in MD?*, ASHLEY ADDICTION TREATMENT, https://www.ashleytreatment.org/addiction-treatment/ [https://perma.cc/XBL7-VNUV] ("Every individual's road to addiction is unique.").

learning disability is the "condition[], manner, or duration" of the purported limitation, as regulations prescribe.[359] Under this interpretation, a student who strains to earn good grades because of a limitation may be qualified as an individual with a disability notwithstanding the grades themselves. In contrast, the Ninth Circuit held that a student who performed well academically, under the same circumstances as other students, simply could not be an individual with a disability: "[The plaintiff's] claim to be 'disabled' was contradicted by his ability to achieve academic success, and to do so without special accommodations."[360]

The Fourth Circuit, in the addiction context, seemed to side with the Ninth Circuit, categorically equating addiction with an absence of choice much like categorically equating academic achievement with an absence of a disability. Indeed, the Fourth Circuit was satisfied with a blanket statement that the individuals possess an addiction, declining to engage in an individualized inquiry as to the nature of the individual's addiction as it relates to their conduct.[361]

In the disability context, Congress has expressly rejected a categorical approach in which an individual would be considered an individual with a disability on the basis of label or diagnosis alone. More specifically, Congress has made clear that having a diagnosed impairment will not automatically satisfy the definition of having a disability.[362] Instead, Congress emphasized that the conditions, manner, and duration under which the individual lives are what matter for purposes of disability determinations.[363]

While Congress has codified the individualized approach taken by the Second Circuit in the learning disability context, it has yet to do so with the Fourth Circuit's categorical approach in the addiction context. The diverse presentations of addiction, the unique paths to recovery, and the courts' related insistence on individualized assessments of physical and mental impairments, all undermine this categorical approach. Professors Richard Holton and Kent Berridge counsel that, "We should . . . not be thinking of addictive desires as things that are impossible to resist, but as things that are

359. Bartlett v. N.Y. State Bd. of L. Exam'rs, 226 F.3d 69, 80 (2d Cir. 2000) (emphasis omitted).

360. Wong v. Regents of Univ. of Cal., 410 F.3d 1052, 1065 (9th Cir. 2005); *see also id.* ("Most notably, Wong completed the first two years of the medical school program, the academic courses, on a normal schedule, with a grade point average slightly above a 'B,' and he passed the required national board examination at that point, both without the benefit of any special accommodations.").

361. *See* Manning v. Caldwell, 930 F.3d 264, 281–84 (4th Cir. 2019) (en banc).

362. *See* 35 C.F.R. § 35.108(d)(1)(v) (2020).

363. *See Id.* § 35.108(d)(3).

very difficult to resist."[364] The courts should probe the nature of that difficulty on an individual basis.

This discussion suggests that various factors—the lucid intervals during which an individual with an addiction may be aware of their addiction and the adverse consequences of addictive addiction, the moral and social responsibility to mitigate the harms stemming from the addiction, and viable options to fulfill that responsibility—support the conclusion that an individual with an addiction may be capable of the choice necessary for criminal liability to attach. This determination is further bolstered by the distinction between addiction and involuntariness, and the impropriety of categorically assessing addiction.

C. *Addiction and the Purposes of Punishment*

The argument that an individual with alcohol or drug disease is amenable to punishment must be consistent with the underlying purposes of punishment. These purposes supply the theoretical and principled foundation for criminal law. Each of the traditional justifications for the imposition of punishment—retribution, deterrence, incapacitation, and rehabilitation—support the application of general criminal liability to an individual with drug or alcohol disease.[365]

First, retributive theory authorizes the imposition of punishment on the individual with alcohol or drug disease. Retribution provides that an individual deserves punishment because they are morally responsible for inflicting harm or risk of harm on society.[366] To a retributivist, the individual is a moral agent capable of choice and, if the individual decides to violate the law, society must impose consequences on the individual for that choice.[367] Retribution thus pays respect to the moral agency of the individual and completes the bargain that the social contract sets forth: if you break the law, you are owed punishment.[368]

An individual with diminished capacity is less deserving of punishment in a retributivist system.[369] From this lens, it may be tempting to suggest that

364. Richard Holton & Kent Berridge, *Compulsion and Choice in Addiction*, *in* ADDICTION AND CHOICE: RETHINKING THE RELATIONSHIP 153, 155 (Nick Heather & Gabriel Segal eds., 2017).

365. *See* Gorham v. United States, 339 A.2d 401, 422–23 (D.C. 1975).

366. *See* H.L.A. HART, PUNISHMENT AND RESPONSIBILITY 9 (2d ed. 1968) (defining retribution as "the application of the pains of punishment to an offender who is morally guilty").

367. *See* Dawinder S. Sidhu, *Moneyball Sentencing*, 56 B.C. L. REV. 671, 677–78 (2015).

368. *Id.* ("[U]nder a retributivist framework, the offender is paying a 'debt' owed to society for the improper 'benefits and burdens' that he or she received from or imposed on others, which, when paid, restores an equilibrium within society.").

369. *See id.* at 708 ("Our criminal law . . . does not . . . punish those who cannot make moral choices for themselves, such as children, the intellectually disabled, or the insane. These individuals are considered categorically ineligible for criminal sanction because they cannot be 'blameworthy in

an individual with an alcohol or drug disease is less deserving of punishment because their disease exerts downward pressure on their ability to exercise free will and make a meaningfully voluntary choice as to whether to drink or use.[370] But, as noted above, the person's conscious awareness of the disease, and an unwillingness to address the manifestations of the disease, changes the theoretical dynamic: one is culpable for what one deliberately ignores or fails to sufficiently address.[371] In this sense, punishing the individual with alcohol or drug disease would be consistent with retributive principles.

Second, as Justice Breyer put it, deterrence attempts to ensure, through punishment, that "crime does not and will not pay."[372] An individual with an alcohol or drug disease may be deterred insofar as they are consciously aware of their actions. Conscious awareness enables a possible weighing of competing considerations, including any probability of detection and punishment.

Third, incapacitation offers the strongest basis for punishment of an individual with an alcohol or drug disease. Incapacitation is premised on the notion that punishment should be designed to physically separate the wrongdoer from others, thus limiting their ability to engage in further harmful actions.[373] Blackstone wrote that incapacitation "depriv[es] the party injuring of the power to do future mischief."[374] Here, incapacitation would support the imposition of punishment even as to involuntary acts because the individual is incapable of self-regulation and has revealed an inability to keep themselves within the bounds of the law. Judge Posner observed, for example, that an individual suffering from a condition warrants a "heavier sentence" under

mind'; they lack the requisite mental capacity to meaningfully choose between good and evil." (quoting Morissette v. United States, 342 U.S. 246, 252 (1952))).

370. *See* Alfred Blumstein, *The Search for the Elusive Common "Principle"*, 82 NW. U. L. REV. 43, 47 (1988) ("[T]ake two convicted robbers, one of whom is found to be a heavy user of drugs and the other who is not. In desert terms, the drug-user deserves a lesser sentence because the drugs had affected his behavior, leaving him with diminished capacity. Many would thus adjudge him less blameworthy than a non-drug-abusing robber.").

371. *See* Mirko Bagaric & Sandeep Gopalan, *A Sober Assessment of the Link Between Substance Abuse and Crime — Eliminating Drug and Alcohol Use from the Sentencing Calculus*, 56 SANTA CLARA L. REV. 243, 278 (2016) ("[A]ddiction . . . may be less mitigating . . . where the defendant has had numerous opportunities for treatment and has either declined drug treatment or failed to meaningfully attempt to complete drug treatment." (quoting United States v. Hendrickson, 25 F. Supp. 3d 1166, 1175 (N.D. Iowa 2014))).

372. *See* Stephen Breyer, *The Federal Sentencing Guidelines and the Key Compromises upon Which They Rest*, 17 HOFSTRA L. REV. 1, 47 (1998).

373. *See* Miller v. Alabama, 567 U.S. 460, 515 (2012) (Alito, J., dissenting) ("If imprisonment does nothing else, it removes the criminal from the general population and prevents him from committing additional crimes in the outside world."); Lynne N. Henderson, *The Wrongs of Victim's Rights*, 37 STAN. L. REV. 937, 989 (1985) ("Proponents of the incapacitation approach believe that the best way to prevent a particular offender from committing future crimes is to remove him from society.").

374. 4 WILLIAM BLACKSTONE, COMMENTARIES *11–12.

incapacitation principles because that sentence "will reduce his lifetime criminal activity by incapacitating him for a longer time than if he received a lighter sentence."[375] Similarly, the individual who claims that their drinking or using is compelled by disease and beyond their control would be making a classic case for punishment under incapacitation principles: a person who cannot stop crossing the line must be separated from society so as to protect that society, irrespective of the reasons for the lack of control.

Finally, the rehabilitative theory of punishment also strongly justifies the imposition of punishment on an individual with alcohol or drug disease. The rehabilitative theory posits that punishment is appropriate to reform or correct the individual's behavior.[376] This personal growth and development inures not only to the benefit of the individual but also to the society to which they will return, as the individual will pose less danger to society and will be more likely to make positive contributions to their community.[377]

Today, rehabilitation is most associated with treatment and formal programs calculated to enhance the personal and professional capacities of the individual. This programmatic support may cover alcohol and substance abuse disorders, co-occurring mental health disorders, anger management, skills development, vocational training, and educational programs.[378] An individual with alcohol or drug disease is an appropriate subject of punishment under the rehabilitative purpose of punishment because punishment is an opportunity for the disease to be treated and its effects to be mitigated. Drug courts demonstrate this principle in action.[379] Data also shows that treatment can be an effective means to address the disease and reduce recidivism.[380]

In short, the purposes of punishment do not undermine the conclusion that criminal punishment may be imposed on an individual with an alcohol or drug disease. Indeed, each purpose, especially incapacitation and rehabilitation, provides support for the imposition of such punishment.

375. United States v. Garthus, 652 F.3d 715, 718 (7th Cir. 2011).

376. United States v. Cole, 622 F. Supp. 2d 632, 638 (N.D. Ohio 2008).

377. Sidhu, *supra* note 367, at 679.

378. *See Principles of Drug Addiction*, *supra* note 108, at 5 ("Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.").

379. *See supra* notes 353–56 and accompanying text.

380. *See* Ethan G. Kalett, Note, *Twelve Steps, You're Out (Of Prison): An Evaluation of "Anonymous Programs" as Alternative Sentences*, 48 HASTINGS L.J. 129, 139 (1996) ("Yet most studies show that while traditional parole/probation has failed to decrease recidivism in addicted offenders, placing such offenders in drug and alcohol treatment programs does decrease recidivism."); *see also id.* at 149 ("A.A. itself claims to have lowered recidivism among criminal alcoholics by 60% . . . .").

D. *Evidence of Choice*

The prior sections suggest that the status-conduct distinction is inadequate because it fails to require an individual with an addiction to show, as required by Justice White's controlling opinion, that the disease of addiction actually precluded compliance with the law. At the same time, the alternative approach championed by the Fourth Circuit, which accepted the diagnosis of an addiction as sufficient proof of involuntariness, is also flawed. It is clear as a medical and clinical matter, not to mention from parallel legal contexts, that a diagnosis is not an automatic or categorical bar to seeking and obtaining help. It also is clear from the previous discussion that an individual with an addiction who violates the law is a proper subject of criminal punishment, even if the unlawful act is symptomatic of the disease. This section describes how the Fourth Circuit should have engaged in an individualized inquiry to determine voluntariness in the case before it.

Showing of Involuntariness. The question left unanswered by Justice White's concurring opinion and by the Fourth Circuit opinion is: What would it take for an individual with an addiction to demonstrate that their actions were involuntary for purposes of criminal law? Based on the foregoing discussion, several factors emerge that may help courts determine whether such conduct is involuntary.

First, an individual who drinks or uses drugs may have a conscious awareness, between periods of consumption or even during periods of consumption, that drinking or using is problematic for them.[381] These moments of awareness serve as opportunities to address the disease and its manifestations.[382] A court seeking to determine whether an individual with drug or alcohol disease should be held criminally liable for a prohibited act should therefore ask whether any such opportunities, or "lucid intervals," existed. If they did, and the individual still did not take meaningful, ongoing action, the responsibility for the uncorrected manifestation of the disease may be attributed to the individual; the decision to forgo help is itself a choice.[383]

Second, even if the individual has the opportunity to seek help, actually obtaining help may be a different story. An individual wanting to address their addiction to drugs or alcohol generally has options, including calling emergency services and detoxifying or receiving other treatment in a hospital setting. But it also may be possible that, although the individual has made meaningful efforts to seek treatment, treatment is not yet feasible. Some facilities may be at capacity or may have waiting lists for admission, effectively precluding the individual from obtaining help notwithstanding

381. *See supra* notes 321–22 and accompanying text.
382. *See supra* notes 325–26 and accompanying text.
383. *See supra* notes 333–37 and accompanying text.

their demonstrated desire to address their addiction.[384] As with the Ninth Circuit case in which homeless individuals avoided criminal liability because area homeless shelters were full,[385] a court exploring whether an individual with an addiction may be held criminally responsible should examine both the affirmative efforts made by the individual to receive help and the availability of any appropriate help.

Third, even if the individual is unable to receive help, despite the reasonable pursuit of it, the absence of any immediately accessible treatment opportunities is not a license to drink or use. Since addiction is not monolithic, it presents itself differently for different people, so a court should look into the conditions during any period in which help was sought but could not be secured.

For example, an individual who drinks or uses in this interval on account of averting severe withdrawal symptoms may be able to make a stronger argument of involuntariness than a person who used without withdrawal symptoms looming over their head.[386] Individuals with drug or alcohol disease may hunt for their drug of choice specifically to avoid or at least delay withdrawal symptoms.[387] The importance of withdrawal in the context of criminal law finds support in existing law. In both *Robinson* and *Powell*, the Supreme Court pointed out that neither defendant was drinking alcohol to address actual or imminent withdrawal symptoms.[388] In *Powell*, the plurality additionally suggested that the loss of control or volition over drinking might occur when the individual drinks alcohol in response to withdrawal.[389]

384. *See* Cristina Redko, Richard C. Rapp & Robert G. Carlson, *Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users*, 36 J. DRUG ISSUES 831, 837–38, 841–42 (2006); Stacey C. Sigmon, Taylor A. Ochalek, Andrew C. Meyer, Bryce Hruska, Sarah H. Heil, Gary J. Badger, Gail Rose, John R. Brooklyn, Robert P. Schwartz, Brent A. Moore & Stephen T. Higgins, Correspondence, *Interim Buprenorphine vs. Waiting List for Opioid Dependence*, 375 NEW ENG. J. MED. 2504, 2504 (2016) ("Despite the demonstrated efficacy of maintaining abstinence by treating patients with opioid agonists, patients can remain on clinic waiting lists for months . . . .").

385. *See* Martin v. City of Boise, 902 F.3d 1031, 1048 (9th Cir. 2018), *aff'd in part*, *rev'd in part*, 920 F.3d 584 (2019).

386. A number of excellent articles describe the "sheer hell" that is withdrawal. *See, e.g.*, O'Malley, *supra* note 91; Brian Rinker, *What "Dope Sick" Really Feels Like*, CAL. HEALTHLINE (Feb. 8, 2019), https://californiahealthline.org/news/what-dope-sick-really-feels-like/ [https://perma.cc/VPE4-JARY]; Matthew Rozsa, *Opioid Addicts on How They Got Addicted*, SALON (May 24, 2019, 10:00 P.M.), https://www.salon.com/2019/05/24/opioid-addicts-on-how-they-got-addicted [https://perma.cc/G72K-98SF].

387. *Drugs, Brains, and Behavior*, *supra* note 80, at 24 (noting that treatment designed to reduce withdrawal symptoms "makes it easier to stop the drug use").

388. Powell v. Texas, 392 U.S. 514, 525 (1968) (plurality opinion); Robinson v. California, 370 U.S. 660, 662 (1962).

389. *See Powell*, 392 U.S. at 525 ("[I]t cannot accurately be said that a person is truly unable to abstain from drinking unless he is suffering the physical symptoms of withdrawal."); *see also* L.S. Tao, *Alcoholism as a Defense to Crime*, 45 NOTRE DAME L. REV. 68, 77 (1969) (suggesting that an individual with alcoholism may not avoid criminal responsibility if "he retains mastery over his

These three nonexhaustive factors—awareness and attendant action, availability of help, and nature of the addiction—should help guide a court's particular, individualized inquiry as to whether the individual possesses the culpability sufficient for criminal liability to be appropriate. The Fourth Circuit did not engage in this analysis, categorically equating the label or diagnosis of addiction with involuntariness.[390]

To be sure, the case rose to the Fourth Circuit on a motion to dismiss and, on such a motion, a court is to accept the factual allegations of the nonmovant as true.[391] But conclusory allegations—that an individual is compelled to drink on account of the disease of addiction—are insufficient to survive a motion to dismiss.[392] The complaint must contain factual support enabling the court to infer that the allegations are plausible.[393]

Application. Here, the Fourth Circuit accepted the five plaintiffs' bare conclusions that they were compelled to drink, without digging deeper as an evidentiary approach would require and as a sufficient analysis of a motion to dismiss does require. A proper examination of the complaint indicates that one plaintiff would survive the motion, while four would fall short.

The complaint states that the five plaintiffs "suffer from alcohol use disorder," which is a "disease," and that the plaintiffs "have a profound drive or craving to use alcohol, which is a compulsive or non-volitional aspect of addiction."[394] This blanket statement is inadequate to surpass a motion to dismiss as it equates the disease itself with compulsion, restates a legal conclusion that any drinking by an individual with the disease is nonvolitional, does not indicate that the individuals lacked any lucid intervals, and does not indicate whether the plaintiffs lacked meaningful options to respond to their addiction. An individualized inquiry under the evidentiary model would further probe each of the plaintiffs' specific conditions and circumstances.

The complaint notes that the named plaintiff, Cary Hendrick, has been in treatment programs, has not been able to stay sober, and has withdrawal symptoms without alcohol.[395] Previous unsuccessful efforts at mitigation do not, however, entitle the individual to forgo future efforts. Indeed, treatment

course of behavior insofar as he could stop drinking without triggering these serious physical withdrawal symptoms").

390. *See* Manning v. Caldwell, 930 F.3d 264, 281 (4th Cir. 2019) (en banc).

391. Hendrick v. Caldwell, 232 F. Supp. 3d 868, 875–76 (W.D. Va. 2017), *vacated sub nom.*, *Manning*, 930 F.3d at 264.

392. *See* Ashcroft v. Iqbal, 556 U.S. 662, 681 (2009) ("It is the conclusory nature of [a plaintiff's] allegations . . . that disentitles them to the presumption of truth.").

393. *See id.* at 678–80.

394. Complaint for Declaratory and Injunctive Relief ¶¶ 23–25, *Hendrick*, 232 F. Supp. 3d 868 (No. 7:16-CV-0095) [hereinafter Complaint].

395. *Id.* ¶¶ 46–47.

programs are not designed to be the be-all-end-all; they are the training wheels that are designed to empower the individual to maintain sobriety through their own developed support system.[396] Moreover, it is not uncommon for individuals to receive treatment multiple times before treatment sticks or clicks.[397] In addition, individuals may enter treatment at one level, only to require more acute care.[398] A person with a visual impairment would be expected to continue finding corrective lenses that were effective rather than proceeding through life blind, consequences be damned. Critically, the complaint does not reveal that Hendrick lost awareness of the manifestations of his disease, was deprived of any opportunities to receive additional or higher levels of care, or was compelled to use while awaiting access to appropriate care.[399] If anything, the complaint describes an individual who tried treatment and tried no more.[400] Recovery only "works if you work it,"[401] or put forth persistent and ongoing corrective efforts. The same flaws and shortcomings in Hendrick's allegations also appear for the other plaintiffs.[402]

The only plaintiff that may satisfy a motion to dismiss under the evidentiary model is Ryan Williams. The complaint alleges that he suffers withdrawal symptoms if he does not consume alcohol.[403] This allegation, accepted as true at the motion to dismiss stage, would cut in favor of a finding of involuntary use of alcohol. Whether this fact holds up can and should be assessed at a later phase of the case.

Whether an individual with addiction to drugs or alcohol is a proper subject of criminal punishment requires a fact-based inquiry. This section demonstrates—through the application of the evidentiary model to *Manning*—

396. *See Principles of Drug Addiction*, *supra* note 108, at 9.

397. *See Drugs, Brains, and Behavior*, *supra* note 80, at 23 ("When a person recovering from an addiction relapses, it indicates that the person needs to speak with their doctor to resume treatment, modify it, or try another treatment."); *Principles of Drug Addiction*, *supra* note 108, at 10 ("Successful treatment for addiction typically requires continual evaluation and modification as appropriate, similar to the approach taken for other chronic diseases.").

398. *See* Leslie C. Morey, *Patient Placement Criteria: Linking Typologies to Managed Care*, 20 ALCOHOL HEALTH & RSCH. WORLD 36, 39 (1996).

399. The complaint states that he suffers from seizures if he does not have access to alcohol, but also adds that he takes medication to control the seizures. Complaint, *supra* note 394, ¶ 47.

400. *See* Complaint, *supra* note 394, ¶ 46.

401. *See Recovery Slogans*, 12STEP.ORG, https://www.12step.org/references/commonly-used/recovery-slogans/ [https://perma.cc/5PD5-9QHG].

402. *See* Complaint, *supra* note 394, ¶¶ 53, 59 (Bryan Manning); *id.* ¶¶ 66, 72 (Ryan Williams); *id.* ¶ 79 (Richard Deckerhoff); *id.* ¶¶ 93, 97 (Richard Eugene Walls). To be sure, it seems that some of the plaintiffs may have been arrested without having any alcohol in their system, *see*. *id.* ¶ 52 (noting that Manning was arrested due to "smelling like alcohol"); *id.* ¶¶ 77, 92 (asserting that Mr. Walls was arrested due to "empty beer cans" being nearby), which would seem to run afoul of *Robinson v. California*, 370 U.S. 660, 667 (1962).

403. Complaint, *supra* note 394, ¶ 73. The named plaintiff also references withdrawal symptoms, *id.* ¶ 47, but also concedes that the symptoms are managed with medication, *id.*

that the proposed model is workable, and therefore has the hallmarks of a sound and durable legal regime.

CONCLUSION

This Article aims to update the response to the fundamental question of whether an individual who possesses an alcohol or substance use disorder may face criminal liability for conduct that is symptomatic of that disorder. A renewed understanding of the relationship between criminal law and addiction is required for several reasons, including the evolution of social attitudes and scientific knowledge respecting addiction, and a crisis within the federal circuit court of appeals on the applicability of criminal liability to conduct symptomatic of addiction.

This Article argues that the majority approach taken by the federal appellate courts wrongly asks only whether the criminal offense contains an actus reus and that the Fourth Circuit approach wrongly immunizes the individual with an addiction from criminal liability, with both regimes staking out categorical rules that fail to probe the individualized nature of addiction. An individualized inquiry—guided by considerations of conscious awareness, practical opportunities to receive help, and the nature of the addiction—would properly reflect the Supreme Court's guideposts in this field, match Congress's determinations in the disability space, and align with the fact that addiction is not a monolithic disease but one whose presentations and related experiences are different for each afflicted person. Moreover, and critically, an individualized inquiry would be consistent with the recognition—supported by case law, scientific information, addiction treatment programs, and twelve-step fellowship literature—that an individual with the disease of addiction generally is capable of exercising choice and that choice is an essential predicate to criminal punishment. As such, the bar to show involuntariness is high, and thus addiction may function as a limited and narrow shield to criminal liability.

This Article seeks to assist courts, litigants, and the public by providing a descriptive survey of the relationship between criminal law and addiction and by suggesting how that relationship may be refined to best pay tribute both to current knowledge on the subject and to core principles of criminal responsibility.