
MEDICO-LEGAL ASPECTS OF ALCOHOL, DRUGS, AND CRIMINALITY IN GERMANY

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Abstract — A psychiatric assessment of legal responsibility in drug abusers must consider not only the immediate effects of the drug, but also take into account the offender’s psychosocial background and profile at the time of the crime.

INTRODUCTION

Together with the considerable rise of drug-related offences over the past 10 years, the number of first-time users of hard drugs in Germany rose steadily from 2987 cases in 1983 to 14 346 in 1992; it fell to 13 009 in 1993. The drug of choice in 1993 was heroin (59.8%), followed by cocaine (23.1%), amphetamines (13.5%), and LSD (1.2%), with various other drugs making up the remainder (2.4%). At the close of 1993, the number of hard drug users in Germany was estimated to be somewhere between 139 000 and 184 000. Drug seizures (Table 1) revealed a moderate decrease in heroin (the drug of choice), which was, however, offset by a considerable rise in the use of stimulants 3,4-methylenedioxymethamphetamine (MDMA, ‘Ecstasy’), 3,4-methylenedioxymethamphetamine (MDE, ‘Eve’), amphetamine etc. Although the quantity of cocaine seized decreased, cocaine-related crimes in 1993 showed an increase of 21.2% over the previous year, which could indicate a trend away from heroin and towards cocaine, amphetamine, and other stimulants. Generally, users seem to be seeking stimulation rather than sedation, and most first-time consumers are in the age brackets of 21–25 years (28.5%) and 25–30 years (28.3%). A statistical comparison of data from 1983 and 1993 did not, however, confirm the seeming trend of decreasing age amongst first-time users.

THE CLINICAL PICTURE

The immediate and direct effects of a drug-induced ‘trip’ are a disturbed sense of space and time, illusions, hallucinations, and a disturbed perception of self with more or less pronounced mood and personality changes, which may or may not be lasting (Table 2). A loosening of thought patterns contributes to weakening the individual’s grip on reality. Bolstered by an enhanced drive, decreased inhibitions and artificial optimism, users of euphoric drugs tend to take more and greater risks and are less restrained by the legal consequences of their actions. An aggressive mood shift coupled with a decreased ability to resist provocation predisposes towards violence, typically in the cases of alcohol and cocaine-induced paranoia (Lightfoot and Hodgins, 1988). Depravation, a central concept of chronic personality changes associated with chronic drug use, is linked to the duration of physical dependence (Schramm and Kröber, 1994). It is characterized by mental deterioration with progressive loss of judgement, levelling of values, and narrowing of interests exclusively to drug obtainment and consumption. However, if factors such as occupation, interests, motives or emotion are involved, at least a partial recovery may be expected. In abstinent chronic alcoholics, brain shrinkage is partially reversible (Trabert et al., 1995). Depravation in terms of self-centeredness, instability, unreliability, and neglect may overlap partially with the anti-social personality (Sass, 1987). With its general levelling of emotions and values, the

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Table 1. Narcotics seized in Germany in 1993: percentage change relative to 1992

<table>
<thead>
<tr>
<th>Substance</th>
<th>Amount seized (kg)</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>1095</td>
<td>-23.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1051</td>
<td>-21.1</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>108</td>
<td>+ 3.0</td>
</tr>
<tr>
<td>MDMA and MDE</td>
<td>77 481 pills</td>
<td>+329.6</td>
</tr>
<tr>
<td>Hashish</td>
<td>4245</td>
<td>+32.6</td>
</tr>
<tr>
<td>Marijuana</td>
<td>7107</td>
<td>-20.7</td>
</tr>
</tbody>
</table>

A psychopathological profile of depravation can mimic anti-social behaviour, and after a few months of detention — and psychological realignment — the two may be indistinguishable (Schramm and Kröber, 1994).

Nedopil (1994) distinguished four stages in the development of addiction (adapted from Waldmann, 1975). Following a trial stage, new experiences are sought by using drugs, often referred to as ‘expanding the horizons’. In the bonding stage, where the substance is employed in solving conflicts, the individual’s life has already been restructured and drug use made an integral part of his or her psychological orientation. In the final stage, the substance merely serves to avoid withdrawal symptoms and no longer provides any new experiences, but has now assumed a critical role in the decision-making process.

Marijuana and cocaine can trigger schizophrenia-like drug psychoses, or toxic psychoses, as Senay and Wettstein (1983) described for violent Table 2. Psychic effects of substance abuse

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Opioids</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mood</strong></td>
<td>Dose-dependent: cheerful or aggressive</td>
<td>Euphoria</td>
<td>Euphoric, anxiolytic</td>
<td>Euphoria, increased feelings of self-worth</td>
</tr>
<tr>
<td><strong>Drive</strong></td>
<td>Dose-dependent: stimulated or sedated</td>
<td>Passivity, apathy</td>
<td>Dampened mental activity</td>
<td>Heightened activity and contact</td>
</tr>
<tr>
<td><strong>Thinking</strong></td>
<td>Dose-dependent: faster or slower</td>
<td>Difficulty concentrating, decreased attentiveness</td>
<td>Difficulty concentrating</td>
<td>Paranoid experiences</td>
</tr>
<tr>
<td><strong>Perception</strong></td>
<td>Seldom intensified, mostly decreased</td>
<td>Illusions, pseudo-hallucinations</td>
<td>Reduced pain sensation</td>
<td>Acoustic and optical hallucinations</td>
</tr>
<tr>
<td><strong>Willingness to take risks</strong></td>
<td>Increased</td>
<td>Increased</td>
<td>Increased</td>
<td>Increased</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
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<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependence</strong></td>
<td>Psychological and physical Sentimentality, if brutalization and abasement: personality changes</td>
<td>Psychological</td>
<td>Psychological and physical</td>
<td>Psychological</td>
</tr>
<tr>
<td><strong>Personality changes</strong></td>
<td>Increasingly self-absorbed, self-contemplation, amotivational syndrome</td>
<td>Increasingly self-absorbed, self-contemplation, amotivational syndrome</td>
<td>Blind activity, lethargy, apathy</td>
<td>Amotivational syndrome</td>
</tr>
<tr>
<td><strong>Deprivation</strong></td>
<td>Disintegration of family, loss of job</td>
<td>Lack of social interest</td>
<td>Social withdrawal</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td><strong>Cognitive losses</strong></td>
<td>Disturbances of long- and short-term memory (Korsakov)</td>
<td>Disturbances of long- and short-term memory</td>
<td>Social withdrawal</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td><strong>Psychosis</strong></td>
<td>Can occur</td>
<td>Can occur</td>
<td>Can occur</td>
<td>Can occur</td>
</tr>
</tbody>
</table>
criminal drug addicts. These individuals showed an above-average drug consumption for months or years on end, alternately used stimulants and tranquillizers, and were usually in some kind of trouble, led a chaotic life-style, related traumatic events, and were mentally disturbed after crime, which they often regretted. The use of stimulants leads to dysphoric fears, irritability, and rage, which in turn require tranquillizers, thus leading to an upward spiral of increased dosages for both substances. The users did retain the awareness that 'something would happen' under these high dosages. The distinguishing feature of toxic psychoses consists in a dosage-dependent ego disturbance, including grasp on reality and judgement. Less commonly, drug use can be followed by delayed psychotic disturbances or flashbacks.

**NEW DEVELOPMENTS: 'EVE' AND 'ECSTASY'**

'Eve' and 'Ecstasy' began to spread amongst students, white-collar professionals and New Age followers in the USA, UK, the Netherlands, and Germany chiefly at 'Techno' parties. Their use is characterized by unchanging dosages between relatively large time intervals (days to months). Continued use causes a decreased 'kick' and more pronounced side- and after-effects. A minority of users show increased dosage and frequency of intake. MDE and MDMA are sought after for their pleasant and relaxing action, the same properties for which they were used in psycholytic and psychodelic psychotherapy in the 1950s and 1960s; low dosages cause lowering of defences and symbolic visualization of repressed material, thereby facilitating analysis and therapy; a single high dose causes an overwhelming religious-mystical experience. The Swiss Community of Physicians for Psycholytic Therapy (Schweizerische Ärztgesellschaft für Psycholytische Therapie, SÄPT), founded in 1985 — the year MDMA was outlawed by the Food and Drug Administration (FDA) in the USA — used LSD and MDMA to treat patients until 1994.

In a placebo-controlled trial on 14 healthy volunteers, Gouzoulis-Mayfrank et al. (1996) found that acute psychic effects of 'Eve' ranged from relaxation and loss of fear to contentment and euphoria, altered time sense, disturbances of concentration and perception, such as seeing colours more intensely, distorted outlines, objects seeming larger or smaller and sounds louder, and 'feeling things through cotton', as some subjects described it. Somatic changes included increased vigilance, talkativeness, heart rate, and blood pressure, as well as slight tremors. Subjects did retain self-control. Acute psychic effects of 'Ecstasy', as reported in an anonymous interview of 100 students in the USA, include a feeling of closeness to other people, increased vigilance and reactions, disturbed concentration, tingling sensation, and sleep disturbances. Optic perception is disturbed — vision is blurred and distorted, objects seem to shine, users may experience illusions and pseudohallucinations. Somatic effects include 'locked' jaw, grinding of teeth, accelerated heart rate, palpitations, dry mouth, trembling, sweating, hot flashes, chills, dizziness, and nausea. 'Ecstasy' can cause after-effects the next day, including sleepiness, sore muscles, depressed mood, difficulty in concentrating, headache, dry mouth, restlessness, anxiety, and irritability. Physical withdrawal symptoms are seen as signs of addiction and range from slight (sweating, tremors, and restlessness) to severe (including disorientation, confusion, exaggerated affect, illusions, hallucinations, and free association of stimuli and ideas). Delirium can be caused by alcohol, amphetamine, and chronic marijuana use, as well as withdrawal of cocaine, narcoleptics, tranquillizers, and pain killers.

Phencyclidine (PCP) is less prevalent in Germany than in the USA. It is commonly associated with bizarre acts of violence, but its importance in developing addiction is difficult to ascertain since it is often used with other drugs (Wish, 1986).

**DRUGS AND LEGAL CONSEQUENCES**

Is a confession made under the obvious influence of alcohol or drugs acceptable, and if so, how valid is it? Interviewing 359 inmates in Reykjavik (Iceland), Sigurðsson and Guðjónsson (1994) found that 64% of traffic and 45% of violent offenders admitted to alcoholic intoxication during police interrogation, and that 27% of theft and burglary and 45% of drug-related crimes were committed under the influence of drugs. More than one-third of offenders reported having had withdrawal symptoms during interrogation. Interestingly, they related being confused at the
time, but not significantly more anxious, and none of them claimed to have made a false statement due to alcohol or drug influence.

The high street price of heroin and criminality to finance its supply are often cited as reasons for the legalization of heroin. According to a study in England (Kirby, 1993), more than 93% of young offenders reported taking drugs regularly and financing their supply through theft or burglary, and a study in New South Wales (Australia) estimated expenditures for drugs at US$2000 a week and US$5000 for strongly addicted heavy users (Ellard, 1987). There seems to be a clear relation between the extent of addiction and criminal activity. In a study of 690 individuals referred to the Californian Civic Addiction Program, 35% reported intervals of slight drug consumption, during which their crime and arrest rates were significantly lower than during periods of greater drug use (McGlotlin et al., 1978). In an 11-year cohort study of 243 heroin users in Baltimore, Ball et al. (1982) found that drug possession and dealing during times of use was six times higher than during mostly abstinent periods. Indirectly drug-related offences such as burglary, mugging, and breaking into vehicles were commoner than directly drug-related ones (breaking and entering into chemists, doctors' offices and pharmaceutical warehouses). Thus, for the heavily addicted who do not deal themselves and are solely dependent for their drug supply on others, a steady supply could minimize withdrawal anxiety especially in deprived individuals. As long as drug use stays within manageable limits and sufficient funds are available, criminality as a means of securing a drug supply is unlikely. The highest crime rates are found among part-time workers, whereas individuals with a full-time job hardly commit more crimes than the unemployed (Hammersley et al., 1989). Heroin use and delinquency show similar patterns since individuals with criminal tendencies are also prone to drug use (Haggerty et al., 1989).

An aggressive temper and poorly developed conscience and remorse, coupled with a low tolerance of frustration and boredom, as well as the inability to postpone gratification are amongst the personality traits predisposing towards delinquency and drug use (Sass, 1987). The financial burdens of opioid use, progressive physical deterioration, and decline in performance aggravate the situation of individuals inherently incapable of long-term self-support. Insecure and unstable personalities see drugs as a means of counterbalancing these tendencies. Substances such as cannabinoids, with their characteristic 'high' and relaxing action, relieve users of feelings of low self-worth. Joining the drug world and living with delinquents provides contacts for inhibited and narcissistic individuals (Schramm and Kröber, 1994), but also constitutes a major risk of becoming addicted. Those with weak egos in need of constant reassurance by others and who are easily discouraged by criticism and rejection are liable to construct an exaggerated image of themselves, typically one of strength and superiority, which they feel they must prove by commensurate deeds. When reality does not correspond to fantasy, they resort to euphoric drugs. The risk of unstable personalities developing a drug habit has an inverse relationship to social conditions and so this is where case histories and personal backgrounds are of the utmost forensic importance. Strong social risk factors are substance abuse by parents, siblings and/or peers, a weak family, and a marginalized community or ghetto (Shaffer et al., 1987). Individual risk factors, in part deriving from social factors, are early and frequent asocial and/or criminal behaviour, living with delinquents, low education and training (unskilled or manual worker), school dropout, and chronic unemployment. It is important to determine whether disintegration of the family, loss of occupation, and a change of acquaintances are indeed consequences of drug use and that drug use was not initiated by private or professional losses.

According to the National Youth Study, 50% of violent juvenile offenders show a multiple abuse of illegal drugs, 40% of them immediately prior to committing the crime (Haggerty et al., 1989). According to data from the Heidelberg delinquency study on 129 apprehended violent offenders, 78% had used illegal drugs at some point in time, and 27% of them used hard drugs, but only 5% were using drugs at the time of arrest. Of 232 cases studied at the Heidelberg Hospital, 26% had a history of drug and medication abuse, but only 2.1% were addicted at the time of examination (Schramm and Kröber, 1994). A study on 103 female inmates in New South Wales (Australia) showed that 78% had taken illegal drugs prior to
their arrest, and 66% used heroin daily (Ellard, 1987). A multi-centre study (Lightfoot and Hodgins, 1988) on 275 inmates in US gaols revealed that about 80% had taken at least one illegal drug during the 6 months prior to arrest.

It must be pointed out that drug use is not synonymous with addiction, and that abuse and dependence can alternate with a drug-free state. Furthermore, not every crime committed under the influence of drugs can be traced exclusively to drug use. Criminal habits and tendencies can exist long before any use of hard drugs begins, and the drug use may itself be a consequence of these habits. Conversely, drug use may be discontinued spontaneously without any special therapy, i.e. people may simply outgrow it. The risks of i.v. administration (AIDS, hepatitis, overdose), the danger of addiction, and the social stigma of the junkie are not serious deterrents.

ASSESSMENT OF LEGAL RESPONSIBILITY

Assessment and legal outcome are summarized in Fig. 1. In Germany, legal responsibility is assessed at two levels (Schneider, 1961): on the psychopathological level, where psychological disorder and serious disturbances of consciousness, mental retardation, and other severe psychic disorders are considered; and on the psychopathological/psychological and normative level, where the offender's judgement and self-control are evaluated. According to §20 of the Strafgesetzbuch (StGB, penal code), a person is considered to be not legally responsible if, due to psychopathological disorder, serious disturbance of consciousness, mental retardation or other severe mental disorder, they are incapable of recognizing the wrongfulness of their actions at the time of the crime, or act according to this understanding. On the other hand, a person is deemed to have decreased legal responsibility (§21, StGB) if at the time of the crime the offender's capability of recognizing the wrongfulness of their actions, or to act out of that understanding, is considerably impaired by one of the reasons cited under §20.

Addiction and its consequences are usually considered 'psychopathological disturbances', although many offenders also show traits justifying a diagnosis of 'other severe psychic disorder' (Sass, 1991). The critical question of whether the offender was capable of recognizing the wrongfulness of an action follows from the psychopathological profile at the time of crime and at the time of medical examination, the kind and quantity of the drug used, when (and together with what else) it was taken, any existing personality changes or

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**Fig 1. Legal consequences of substance abuse.**
deprivation, degree of addiction, eventual withdrawal symptoms, as well as eventual organic brain changes. Hence, a diagnosis of 'drug addiction' is not forensically relevant if it is made without a psychopathological background of the offender's profile at the time of the crime.

According to German law, a drug addict shows a considerable decrease in discerning faculties if: (1) long-time narcotics use has caused grave personality changes; (2) the crime was committed under severe withdrawal symptoms; or eventually (3) if the crime was committed under the influence of drugs [BGHR, Bundesgerichtshofsprechung (Supreme Court ruling)]. Extreme cases are rare, however, and these three diagnoses must be evaluated psychopathologically for each individual case to avoid StGB §21 becoming a loophole (Schramm and Krober, 1994); i.e. a heroin addict who at the time of the crime was supposedly experiencing violent somatic distress with diarrhoea, abdominal cramps and generalized pain would hardly be capable of committing any crime.

The two-step assessment of 'withdrawal anxiety' must be approached with particular care, because this does not seem to refer to acute withdrawal syndrome or to any milder variety thereof. If it only refers to the transition from subsiding drug effects to the anticipation of withdrawal symptoms, then there is no legal term for this condition. Nevertheless, withdrawal anxiety is used to coerce addicts into crimes, and this has been accepted as diminished judgement. Taschner and Wanke (1973) saw a suspension of legal responsibility only in the case of simultaneous dependence, severe chronic intoxication, and personality changes. Far commoner are the milder forms, incorporation of drugs into a freely chosen anti-social life-style, as well as the excuse, common amongst drug users, of having had withdrawal symptoms ('turkey') or withdrawal anxiety. In fact, given that heroin withdrawal is usually quite unremarkable and in no way life-threatening, a heroin addict undergoing withdrawal cannot automatically be considered legally irresponsible.

**PUNISHMENT VS TREATMENT**

Whereas StGB §64 mandates controlled withdrawal in a medical institution, with the intent of protecting society from the offender, BtMG (Betäubungsmittelgesetz, narcotics law) §35 places the emphasis on treatment, and according to BtMG §38 an ongoing therapy takes precedence over punishment, protecting the offender from further harm to their health. Thus, the decision whether to punish or to treat is independent of legal responsibility. (It may be argued that forcible withdrawal is pointless since no inner motivation exists, but the fact is that many addicts — including alcoholics — do not consider themselves sick, and therefore see no need for treatment.) Further to the statutes forbidding acquisition, possession, and circulation of narcotics, Chatterjee (1984) has raised the interesting point that addiction is in itself a crime since it runs counter to an individual's basic responsibility for his or her own welfare. Similarly, addiction can also be seen as a psychic disturbance, as it is in part the individual's own decision to start (Sass, 1996).

Harsher punishments do not seem to reduce drug-related delinquency. The State of California (USA) raised the penalty for a third heroin-related arrest to 15 years without affecting heroin use (Öjesjö, 1983). Leukefeld (1985) reported success rates of 27–32% abstinence for opioid addicts who underwent supervised withdrawal therapy, with delinquents undergoing supervised withdrawal under parole showing higher rates than voluntary patients.

The compulsory therapy programme, Treatment Alternative to Street Crime (TASC), which empowered therapists to follow uncompliant addicts before lifting parole, had good results. Öjesjö (1983) cited a prospective 20-year study by Vaillant, where a community-based care programme for drug addicts was successful because it not only stressed abstinence, but also offered occupations and maintained regular contacts. Low-level group therapies which do not demand abstinence, are not likely to be successful in a penal setting. No data are available yet on the methadone substitution programme as relating to StGB §64.

**CONCLUSIONS**

Medical and therapeutic measures alone may not be sufficient in dealing with the social and legal problems of drug addiction. Withdrawal programmes rely on reward-and-punishment stra-
tategies to achieve the desired conditioning; legal reinforcement may be helpful.

REFERENCES


BGHR (Bundesgerichtshofsrechtsprechung, supreme court ruling) (1991) StGB §21 BtM-Auswirkungen 2, 4, 5, 6.


