The Ethics of Addiction

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Szasz attacks the World Health Organization definition of drug addiction and propaganda used to justify the prohibition of drugs. He offers an account of drug addiction that is different from the disease model, and argues that adults have a constitutional and moral right to use drugs.

AN ARGUMENT IN FAVOR OF LETTING AMERICANS TAKE ANY DRUGS THEY WANT TO TAKE

To avoid clichés about “drug abuse,” let us analyze its official definition. According to the World Health Organization, “Drug addiction is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire to need (compulsion) to continue taking the drug and to obtain it by any means, (2) a tendency to increase the dosage, and (3) a psychic (psychological) and sometimes physical dependence on the effects of the drug.”

Since this definition hinges on the harm done to both the individual and society, it is clearly an ethical one. Moreover, by not specifying what is “detrimental,” it consigns the problem of addiction to psychiatrists who define the patient’s “dangerousness to himself and others.”

Next, we come to the effort to obtain the addictive substance “by any means.” This suggests that the substance must be prohibited, or is very expensive, and is hence difficult for the ordinary person to obtain (rather than that the person who wants it has an inordinate craving for it). If there were an abundant and inexpensive supply of what the “addict” wants, there would be no reason for him to go to “any means” to obtain it. Thus by the WHO’s definition, one can be addicted only to a substance that is illegal or otherwise difficult to obtain. This surely removes the problem of addiction from the realm of medicine or psychiatry, and puts it squarely into that of morals and laws.

In short, drug addiction or drug abuse cannot be defined without specifying the proper or improper uses of certain pharmacologically active agents. The regular administration of morphine by a physician to a patient dying of cancer is the paradigm of the proper use of a narcotic; whereas even its occasional self-administration...
by a physically healthy person for the purpose of "pharmacological pleasure" is the paradigm of drug abuse.

I submit that these judgments have nothing whatever to do with medicine, pharmacology, or psychiatry. They are moral judgments. Indeed, our present views on addiction are astonishingly similar to some of our former views on sex. Until recently, masturbation— or self-abuse, as it was called— was professionally declared, and popularly accepted, as both the cause and the symptom of a variety of illnesses. Even today, homosexuality— called a "sexual perversion"— is regarded as a disease by medical and psychiatric experts as well as by "well-informed" laymen.

To be sure, it is now virtually impossible to cite a contemporary medical authority to support the concept of self-abuse. Medical opinion holds that whether a person masturbates or not is medically irrelevant; and it is a matter of personal morals or lifestyle. On the other hand, it is virtually impossible to cite a contemporary medical authority to oppose the concept of drug abuse. Medical opinion holds that drug addiction is a disease similar to diabetes, requiring prolonged (or life-long) and careful, medically supervised treatment; and that taking or not taking drugs is primarily, if not solely, a matter of medical responsibility.

Thus the man on the street can only believe what he hears from all sides—that drug addiction is a disease, "like any other," which has now reached "epidemic proportions," and whose "medical" containment justifies the limitless expenditure of tax monies and the corresponding aggrandizement and enrichment of noble medical warriors against this "plague."

PROPAGANDA TO JUSTIFY PROHIBITION

Like any social policy, our drug laws may be examined from two entirely different points of view: technical and moral. Our present inclination is either to ignore the moral perspective or to mistake the technical for the moral.

Since most of the propagandists against drug use seek to justify certain repressive policies because of the alleged dangerousness of various drugs, they often falsify the facts about the pharmacological properties of the drugs they seek to prohibit. They do so for two reasons: first, because many substances in daily use are just as harmful as the substances they want to prohibit; second, because they realize that dangerous alone is never a sufficiently persuasive argument to justify prohibition of any drug, substance, or artifact. Accordingly, the more they ignore the moral dimensions of the problem, the more they must escalate their fraudulent claims about the dangers of drugs.

To be sure, some drugs are more dangerous than others. It is easier to kill someone with heroin than with aspirin. But it is also easier to kill oneself by jumping off a high building than a low one. In the case of drugs, we regard their potentiality for self-injury as justification for their prohibition; in the case of buildings, we do not.

Furthermore, we systematically blur and confuse the two quite different ways in which narcotics may cause death: by a deliberate act of suicide or by accidental overdose.

Every individual is capable of injuring or killing himself. This potentiality is a fundamental expression of human freedom. Self-destructive behavior may be regarded as sinful and penalized by means of informal sanctions. But it should not be regarded as a crime or (mental) disease, justifying or warranting the use of the police powers of the state for its control.

Therefore, it is absurd to deprive an adult of a drug (or of anything else) because he might use it to kill himself. To do so is to treat everyone the way institutional psychiatrists treat the so-called suicidal mental patient: they not only imprison such a person but take everything away from him— shoelaces, belts, razor blades, eating utensils, and so forth— until the "patient" lies naked on a mattress in a padded cell— lest he kill himself. The result is degrading tyrannization.
Death by accidental overdose is an altogether different matter. But can anyone doubt that this danger now looms so large precisely because the sale of narcotics and many other drugs is illegal? Those who buy illicit drugs cannot be sure what drug they are getting or how much of it. Free trade in drugs, with governmental action limited to safeguarding the purity of the product and the veracity of the labeling, would reduce the risk of accidental overdose with “dangerous drugs” to the same levels that prevail, and that we find acceptable, with respect to other chemical agents and physical artifacts that abound in our complex technological society.

This essay is not intended as an exposition on the pharmacological properties of narcotics and other mind-affecting drugs. However, I want to make it clear that in my view, regardless of their danger, all drugs should be “legalized” (a misleading term I employ reluctantly as a concession to common usage). Although I recognize that some drugs—notably heroin, the amphetamines, and LSD, among those now in vogue—may have undesirable or dangerous consequences, I favor free trade in drugs for the same reason the Founding Fathers favored free trade in ideas. In an open society, it is none of the government’s business what idea a man puts into his mind; likewise, it should be none of the government’s business what drug he puts into his body.

WITHDRAWAL PAINS FROM TRADITION

It is a fundamental characteristic of human beings that they get used to things; one becomes habituated, or “addicted,” not only to narcotics, but to cigarettes, cocktails before dinner, orange juice for breakfast, comic strips, and so forth. It is similarly a fundamental characteristic of living organisms that they acquire increasing tolerance to various chemical agents and physical stimuli: the first cigarette may cause nothing but nausea and headache; a year later, smoking three packs a day may be pure joy. Both alcohol and opiates are “addictive” in the sense that the more regularly they are used, the more the user craves them and the greater his tolerance for them becomes. Yet none of this involves any mysterious process of “getting hooked.” It is simply an aspect of the universal biological propensity for learning, which is especially well developed in man. The opiate habit, like the cigarette habit or food habit, can be broken—and without any medical assistance—provided the person wants to break it. Often he doesn’t. And why, indeed, should he, if he has nothing better to do with his life? Or, as happens to be the case with morphine, if he can live an essentially normal life under its influence?

Actually, opium is much less toxic than alcohol just as it is possible to be an “alcoholic” and work and be productive, so it is (or, rather, it used to be) possible to be an opium addict and work and be productive. . . .

I am not citing this evidence to recommend the opium habit. The point is that we must, in plain honesty, distinguish between pharmacological effects and personal inclinations. Some people take drugs to help them function and conform to social expectations; others take them for the very opposite reason, to ritualize their refusal to function and conform to social expectations. Much of the “drug abuse” we now witness—perhaps nearly all of it—is of the second type. But instead of acknowledging that “addicts” are unfit or unwilling to work and be “normal,” we prefer to believe that they act as they do because certain drugs—especially heroin, LSD, and the amphetamines—make them “sick.” If only we could get them “well,” so runs this comforting view, they could become “productive” and “useful” citizens. To believe this is like believing that if an illiterate cigarette smoker would only stop smoking, he would become an Einstein. With a falsehood like this, one can go far. No wonder that politicians and psychiatrists love it.

The concept of free trade in drugs runs counter to our cherished notion that everyone must work and idleness is acceptable only under
special conditions. In general, the obligation to work is greatest for healthy, adult, white men. We tolerate idleness on the part of children, women, Negroes, the aged, and the sick, and even accept the responsibility to support them. But the new wave of drug abuse affects mainly young adults, often white males, who are, in principle at least, capable of working and supporting themselves. But they refuse: they “drop out”; and in doing so, they challenge the most basic values of our society.

The fear that free trade in narcotics would result in vast masses of our population spending their days and nights smoking opium or main-lining heroin, rather than working and taking care of their responsibilities, is a bugaboo that does not deserve to be taken seriously. Habits of work and idleness are deep-seated cultural patterns. Free trade in abortions has not made an industrious people like the Japanese give up work for fornication. Nor would free trade in drugs convert such a people from hustlers to hippies.

Indeed, I think the opposite might be the case: it is questionable whether, or for how long, a responsible people can tolerate being treated as totally irresponsible with respect to drugs and drug-taking. In other words, how long can we live with the inconsistency of being expected to be responsible for operating cars and computers, but not for operating our own bodies?

Although my argument about drug-taking is moral and political, and does not depend upon showing that free trade in drugs would also have fiscal advantages over our present policies, let me indicate briefly some of its economic implications.

The war on addiction is not only astronomically expensive; it is also counterproductive. On April 1, 1967, New York State’s narcotics addiction control program, hailed as “the most massive ever tried in the nation,” went into effect. “The program, which may cost up to $400 million in three years,” reported the New York Times, “was hailed by Governor Rockefeller as ‘the start of an unending war.’” In short, the detection and rehabilitation of addicts is good business. We now know that the spread of witchcraft in the late Middle Ages was due more to the work of witchmongers than to the lure of witchcraft. Is it not possible that the spread of addiction in our day is due more to the work of addictmongers than to the lure of narcotics?

Let us see how far some of the monies spent on the war on addiction could go in supporting people who prefer to drop out of society and drug themselves. Their “habit” itself would cost next to nothing; free trade would bring the price of narcotics down to a negligible amount. . . . free trade in narcotics would be more economical for those of us who work, even if we had to support legions of addicts, than is our present program of trying to “cure” them. Moreover, I have not even made use, in my economic estimates, of the incalculable sums we would save by reducing crimes now engendered by the illegal traffic in drugs.

THE RIGHT OF SELF-MEDICATION

Clearly, the argument that marijuana—or heroin, methadone, or morphine—is prohibited because it is addictive or dangerous cannot be supported by facts. For one thing, there are many drugs, from insulin to penicillin, that are neither addictive nor dangerous but are nevertheless also prohibited; they can be obtained only through a physician’s prescription. For another, there are many things, from dynamite to guns, that are much more dangerous than narcotics (especially to others) but are not prohibited. As everyone knows, it is still possible in the United States to walk into a store and walk out with a shotgun. We enjoy this right not because we believe that guns are safe but because we believe even more strongly that civil liberties are precious. At the same time, it is not possible in the United States to walk into a store and walk out with a bottle of barbiturates, codeine, or other drugs.

I believe that just as we regard freedom of speech and religion as fundamental rights, so we should also regard freedom of self-medication as a fundamental right. Like most rights, the right
of self-medication should apply only to adults; and it should not be an unqualified right. Since these are important qualifications, it is necessary to specify their precise range.

John Stuart Mill said (approximately) that a person’s right to swing his arm ends where his neighbor’s nose begins. And Oliver Wendell Holmes said that no one has a right to shout “Fire!” in a crowded theater. Similarly, the limiting condition with respect to self-medication should be the inflicting of actual (as against symbolic) harm on others.

Our present practices with respect to alcohol embody and reflect this individualistic ethic. We have the right to buy, possess, and consume alcoholic beverages. Regardless of how offensive drunkenness might be to a person, he cannot interfere with another person’s “right” to become inebriated so long as that person drinks in the privacy of his own home or at some other appropriate location, and so long as he conducts himself in an otherwise law-abiding manner. In short, we have a right to be intoxicated—in private. Public intoxication is considered an offense to others and is therefore a violation of the criminal law. It makes sense that what is a “right” in one place may become, by virtue of its disruptive or disturbing effect on others, an offense somewhere else.

The right to self-medication should be hedged in by similar limits. Public intoxication, not only with alcohol but with any drug, should be an offense punishable by the criminal law. Furthermore, acts that may injure others—such as driving a car—should, when carried out in a drug-intoxicated state, be punished especially strictly and severely. The right to self-medication must thus entail unqualified responsibility for the effects of one’s drug-intoxicated behavior on others. For unless we are willing to hold ourselves responsible for our own behavior, and hold others responsible for theirs, the liberty to use drugs (or to engage in other acts) degenerates into a license to hurt others.

Such, then, would be the situation of adults, if we regarded the freedom to take drugs as a fundamental right similar to the freedom to read and worship. What would be the situation of children? Since many people who are now said to be drug addicts or drug abusers are minors, it is especially important that we think clearly about this aspect of the problem.

I do not believe, and I do not advocate, that children should have a right to ingest, inject, or otherwise use any drug or substance they want. Children do not have the right to drive, drink, vote, marry, or make binding contracts. They acquire these rights at various ages, coming into their full possession at maturity, usually between the ages of eighteen and twenty-one. The right to self-medication should similarly be withheld until maturity.

In short, I suggest that “dangerous” drugs be treated, more or less, as alcohol is treated now. Neither the use of narcotics, nor their possession, should be prohibited, but only their sale to minors. Of course, this would result in the ready availability of all kinds of drugs among minors—though perhaps their availability would be no greater than it is now, but would only be more visible and hence more easily subject to proper controls. This arrangement would place responsibility for the use of all drugs by children where it belongs: on parents and their children. This is where the major responsibility rests for the use of alcohol. It is a tragic symptom of our refusal to take personal liberty and responsibility seriously that there appears to be no public desire to assume a similar stance toward other “dangerous” drugs.

Consider what would happen should a child bring a bottle of gin to school and get drunk there. Would the school authorities blame the local liquor stores as pushers? Or would they blame the parents and the child himself? There is liquor in practically every home in America and yet children rarely bring liquor to school. Whereas marijuana, Dexedrine, and heroin—substances children usually do not find at home and whose very possession is a criminal offense—frequently find their way into the school.

Our attitude toward sexual activity provides another model for our attitude toward drugs.
Although we generally discourage children below a certain age from engaging in sexual activity with others, we do not prohibit such activities by law. What we do prohibit by law is the sexual seduction of children by adults. The “pharmacological seduction” of children by adults should be similarly punishable. In other words, adults who give or sell drugs to children should be regarded as offenders. Such a specific and limited prohibition—as against the kinds of generalized prohibitions that we had under the Volstead Act or have now with respect to countless drugs—would be relatively easy to enforce. Moreover, it would probably be rarely violated, for there would be little psychological interest and no economic profit in doing so.

THE TRUE FAITH: SCIENTIFIC MEDICINE

What I am suggesting is that while addiction is ostensibly a medical and pharmacological problem, actually it is a moral and political problem. We ought to know that there is no necessary connection between facts and values, between what is and what ought to be. Thus, objectively quite harmful acts, objects, or persons may be accepted and tolerated—by minimizing their dangerousness. Conversely, objectively quite harmless acts, objects, or persons may be prohibited and persecuted—by exaggerating their dangerousness. It is always necessary to distinguish—and especially so when dealing with social policy—between description and prescription, fact and rhetoric, truth and falsehood.

In our society, there are two principal methods of legitimizing policy: social tradition and scientific judgment. More than anything else, time is the supreme ethical arbiter. Whatever a social practice might be, if people engage in it, generation after generation, that practice becomes acceptable.

Many opponents of illegal drugs admit that nicotine may be more harmful to health than marijuana; nevertheless, they urge that smoking cigarettes should be legal but smoking marijuana should not be, because the former habit is socially accepted while the latter is not. This is a perfectly reasonable argument. But let us understand it for what it is—a plea for legitimizing old and accepted practices, and for illegitimizing novel and unaccepted ones. It is a justification that rests on precedent, not evidence.

The other method of legitimizing policy, ever more important in the modern world, is through the authority of science. In matters of health, a vast and increasingly elastic category, physicians play important roles as legitimizers and illegitimators. This, in short, is why we regard being medicated by a doctor as drug use, and self-medication (especially with certain classes of drugs) as drug abuse.

This, too, is a perfectly reasonable arrangement. But we must understand that it is a plea for legitimizing what doctors do, because they do it with “good therapeutic” intent; and for illegitimizing what laymen do, because they do it with bad self-abusive (“masturbatory” or mind-altering) intent. This justification rests on the principle of professionalism—not of pharmacology. Hence we applaud the systematic medical use of methadone and call it “treatment for heroin addiction,” but decry the occasional nonmedical use of marijuana and call it “dangerous drug abuse.”

Our present concept of drug abuse articulates and symbolizes a fundamental policy of scientific medicine—namely, that a layman should not medicate his own body but should place its medical care under the supervision of a duly accredited physician. Before the Reformation, the practice of True Christianity rested on a similar policy—namely, that a layman should not himself commune with God but should place his spiritual care under the supervision of a duly accredited priest. The self-interests of the church and of medicine in such policies are obvious enough. What might be less obvious is the interest of the laity: by delegating responsibility for the spiritual and medical welfare of the people to a class of authoritatively accredited specialists, these policies—and the practices they ensure—relieve.
individuals from assuming the burdens of responsibility for themselves. As I see it, our present problems with drug use and drug abuse are just one of the consequences of our pervasive ambivalence about personal autonomy and responsibility.

I propose a medical reformation analogous to the Protestant Reformation: specifically, a "protest" against the systematic mystification of man's relationship to his body and his professionalized separation from it. The immediate aim of this reform would be to remove the physician as intermediary between man and his body and to give the layman direct access to the language and contents of the pharmacopoeia. If man had unencumbered access to his own body and the means of chemically altering it, it would spell the end of medicine, at least as we now know it. This is why, with faith in scientific medicine so strong, there is little interest in this kind of medical reform. Physicians fear the loss of their privileges; laymen, the loss of their protections.

LIFE, LIBERTY, AND THE PURSUIT OF HIGHS

Sooner or later we shall have to confront the basic moral dilemma underlying this problem: does a person have the right to take a drug, any drug—not because he needs it to cure an illness, but because he wants to take it?

The Declaration of Independence speaks of our inalienable right to "life, liberty, and the pursuit of happiness." How are we to interpret this? By asserting that we ought to be free to pursue happiness by playing golf or watching television, but not by drinking alcohol, or smoking marijuana, or ingesting pep pills?

The Constitution and the Bill of Rights are silent on the subject of drugs. This would seem to imply that the adult citizen has, or ought to have, the right to medicate his own body as he sees fit. Were this not the case, why should there have been a need for a Constitutional Amendment to outlaw drinking? But if ingesting alcohol was, and is now again, a Constitutional right, is ingesting opium, or heroin, or barbiturates, or anything else, not also such a right? If it is, then the Harrison Narcotic Act is not only a bad law but is unconstitutional as well, because it prescribes in a legislative act what ought to be promulgated in a Constitutional Amendment.

The questions remain: as American citizens, should we have the right to take narcotics or other drugs? If we take drugs and conduct ourselves as responsible and law-abiding citizens, should we have a right to remain unmolested by the government? Lastly, if we take drugs and break the law, should we have a right to be treated as persons accused of crime, rather than as patients accused of mental illness? *

These are fundamental questions that are conspicuous by their absence from all contemporary discussions of problems of drug addiction and drug abuse. The result is that instead of debating the use of drugs in moral and political terms, we define our task as the ostensibly narrow technical problem of protecting people from poisoning themselves with substances for whose use they cannot possibly assume responsibility. This, I think, best explains the frightening national consensus against personal responsibility for taking drugs and for one's conduct while under their influence. . . .

To me, unanimity on an issue as basic and complex as this means a complete evasion of the actual problem and an attempt to master it by attacking and overpowering a scapegoat—"dangerous drugs" and "drug abusers." There is an ominous resemblance between the unanimity with which all "reasonable" men—and especially politicians, physicians, and priests—formerly supported the protective measures of society against witches and Jews, and that with which they now support them against drug addicts and drug abusers.

After all is said and done, the issue comes down to whether we accept or reject the ethical principle John Stuart Mill so clearly enunciated: "The only purpose [he wrote in On Liberty] for which power can be rightfully exercised over any
member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will make him happier, because in the opinions of others, to do so would be wise, or even right. . . . In the part [of his conduct] which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

By recognizing the problem of drug abuse for what it is—a moral and political question rather than a medical or therapeutic one—we can choose to maximize the sphere of action of the state at the expense of the individual, or of the individual at the expense of the state. In other words, we could commit ourselves to the view that the state, the representative of many, is more important than the individual; that it therefore has the right, indeed the duty, to regulate the life of the individual in the best interests of the group. Or we could commit ourselves to the view that individual dignity and liberty are the supreme values of life, and that the foremost duty of the state is to protect and promote these values.

In short, we must choose between the ethic of collectivism and individualism, and pay the price of either—or of both.

Review Questions

1. What is the World Health Organization’s definition of drug addiction? Why does Szasz think it involves moral judgments rather than medical ones?
2. According to Szasz, what is the propaganda used to justify the prohibition of drugs?
3. Explain Szasz’s own view of drug addiction. How is it different from the disease model?
4. Why does Szasz think that the war on drugs is counterproductive? What would be the advantages of free trade in drugs?
5. According to Szasz, why should the freedom to self-medicate be a fundamental right? What are the limits of this right?
6. What are the two principle methods of legitimizing policy? Why doesn’t Szasz accept these methods?
7. Explain Szasz’s proposal for medical reformation.
8. How do Mill’s principle and the Declaration of Independence support Szasz’s position?

Discussion Questions

1. Szasz does not offer an explicit definition of drug addiction. How would he define it? Is there such a thing, in his view?
2. What would be the effects of legalizing drugs such as cocaine and heroin? Would there be more bad effects than good effects?
3. If drugs should be prohibited for teenagers, as Szasz says, then why shouldn’t they be prohibited for adults?
4. Szasz claims that his proposal for medical reformation is analogous to the Protestant Reformation. Is this a good analogy? Why or why not?
Against Legalization of Drugs

JAMES Q. WILSON


Wilson replies to those who want to legalize drugs. He makes a case for keeping heroin and cocaine illegal. His main argument is that legalizing these addictive and dangerous drugs will have bad effects in our society, and these bad effects outweigh the costs of keeping them illegal. The bad effects of heroin and cocaine use that justify their illegality include high death rates for users and harm to children, spouses, employers, and others. In addition to his utilitarian argument, Wilson endorses a moral argument for making drugs such as cocaine illegal. Unlike nicotine, he says, cocaine use is immoral—it debases one’s life and alters one’s soul, and that is why it should be illegal.

In 1972, the President appointed me chairman of the National Advisory Council for Drug Abuse Prevention. Created by Congress, the Council was charged with providing guidance on how best to coordinate the national war on drugs. (Yes, we called it a war then, too.) In those days, the drug we were chiefly concerned with was heroin. When I took office, heroin use had been increasing dramatically. Everybody was worried that this increase would continue. Such phrases as “heroin epidemic” were commonplace.

That same year, the eminent economist Milton Friedman published an essay in Newsweek in which he called for legalizing heroin. His argument was on two grounds: as a matter of ethics, the government has no right to tell people not to use heroin (or to drink or to commit suicide); as a matter of economics, the prohibition of drug use imposes costs on society that far exceed the benefits. Others, such as the psychoanalyst Thomas Szasz, made the same argument.

That was 1972. Today, we have the same number of heroin addicts that we had then—half a million, give or take a few thousand. Having that many heroin addicts is no trivial matter; these people deserve our attention. But not having had an increase in that number for over fifteen years is also something that deserves our attention. What happened to the “heroin epidemic” that many people once thought would overwhelm us?

The facts are clear: a more or less stable pool of heroin addicts has been getting older, with relatively few new recruits. In 1976 the average age of heroin users who appeared in hospital emergency rooms was about twenty-seven; ten years later it was thirty-two. More than two-thirds of all heroin uses appearing in emergency rooms are now over the age of thirty. Back in the early 1970s, when heroin got onto the national political agenda, the typical heroin addict was much younger, often a teenager.

Why did heroin lose its appeal for young people? When the young blacks in Harlem were
asked why they stopped, more than half mentioned “trouble with the law” or “high cost” (and high cost is, of course, directly the result of law enforcement). Two-thirds said heroin hurt their health; nearly all said they had had a bad experience with it. We need not rely, however, simply on what they said. In New York City in 1973–75, the street price of heroin rose dramatically and its purity sharply declined, probably as a result of the heroin shortage caused by the success of the Turkish government in reducing the supply of opium base and of the French government in closing down heroin-producing laboratories located in and around Marseilles. These were short-lived gains for, just as Friedman predicted, alternative sources of supply—mostly in Mexico—quickly emerged. But the three-year heroin shortage interrupted the easy recruitment of new users.

Health and related problems were no doubt part of the reason for the reduced flow of recruits. Over the preceding years, Harlem youth had watched as more and more heroin users died of overdoses, were poisoned by adulterated doses, or acquired hepatitis from dirty needles. The word got around: heroin can kill you. By 1974 new hepatitis cases and drug-overdose deaths had dropped to a fraction of what they had been in 1970.

Alas, treatment did not seem to explain much of the cessation in drug use. Treatment programs can and do help heroin addicts, but treatment did not explain the drop in the number of new users (who by definition had never been in treatment) nor even much of the reduction in the number of experienced users.

No one knows how much of the decline to attribute to personal observation as opposed to high prices or reduced supply. But other evidence suggests strongly that price and supply played a large role. In 1972 the National Advisory Council was especially worried by the prospect that U.S. servicemen returning to this country from Vietnam would bring their heroin habits with them. Fortunately, a brilliant study by Lee Robins of Washington University in St. Louis put that fear to rest. She measured drug use of Vietnam veterans shortly after they returned home. Though many had used heroin regularly while in Southeast Asia, most gave up the habit when back in the United States. The reason: here, heroin was less available and sanctions on its use were much more pronounced.

RELIVING THE PAST

Suppose we had taken Friedman’s advice in 1972. What would have happened? We cannot be entirely certain, but at a minimum we would have placed the young heroin addicts (and, above all, the prospective addicts) in a very different position from the one in which they actually found themselves. Heroin would have been legal. Its price would have been reduced by 95 percent (minus whatever we chose to recover in taxes.) Now that it could be sold by the same people who make aspirin, its quality would have been assured—no poisons, no adulterants. Sterile hypodermic needles would have been readily available at the neighborhood drugstore, probably at the same counter where heroin was sold. No need to travel to big cities or unfamiliar neighborhoods—heroin could have been purchased anywhere, perhaps by mail order.

There would no longer have been any financial or medical reason to avoid heroin use. Anybody could have afforded it. We might have tried to prevent children from buying it, but as we have learned from our efforts to prevent minors from buying alcohol and tobacco, young people have a way of penetrating markets theoretically reserved for adults. Returning Vietnam veterans would have discovered that Omaha and Raleigh had been converted into the pharmaceutical equivalent of Saigon.

Under these circumstances, can we doubt for a moment that heroin use would have grown exponentially? Or that a vastly larger supply of new users would have been recruited?

But we need not rely on speculation, however plausible, that lowered prices and more abundant supplies would have increased heroin
usage. Great Britain once followed such a policy and with almost exactly those results. Until the mid-1960s, British physicians were allowed to prescribe heroin to certain classes of addicts. (Possessing these drugs without a doctor’s prescription remained a criminal offense.) For many years this policy worked well enough because the addict patients were typically middle-class people who had become dependent on opiate painkillers while undergoing hospital treatment. There was no drug culture! The British system worked for many years, not because it prevented drug abuse, but because there was no problem of drug abuse that would test the system.

All that changed in the 1960s. A few unscrupulous doctors began passing out heroin in wholesale amounts. One doctor prescribed almost 600,000 heroin tablets—that is, over thirteen pounds—in just one year. A youthful drug culture emerged with a demand for drugs far different from that of the older addicts. As a result, the British government required doctors to refer users to government-run clinics to receive their heroin.

But the shift to clinics did not curtail the growth in heroin use. Throughout the 1960s the number of addicts increased—the late John Kaplan of Stanford estimated by fivefold—in part as a result of the diversion of heroin from clinic patients to new users on the streets. An addict would bargain with the clinic doctor over how big a dose he would receive. The patient wanted as much as he could get, the doctor wanted to give as little as was needed. The patient had an advantage in this conflict because the doctor could not be certain how much was really needed. Many patients would use some of their “maintenance” dose and sell the remaining part to friends, thereby recruiting new addicts. As the clinics learned of this, they began to shift their treatment away from heroin and toward methadone, an addictive drug that, when taken orally, does not produce a “high” but will block the withdrawal pains associated with heroin abstinence.

Whether what happened in England in the 1960s was a mini-epidemic or an epidemic depends on whether one looks at numbers or at rates of change. Compared to the United States, the numbers were small. In 1960 there were 68 heroin addicts known to the British government; by 1968 there were 2,000 in treatment and many more who refused treatment. (They would refuse in part because they did not want to get methadone at a clinic if they could get heroin on the street.) Richard Hartnoll estimates that the actual number of addicts in England is five times the number officially registered. At a minimum, the number of British addicts increased by thirtyfold in ten years; the actual increase may have been much larger.

In the early 1980s the numbers began to rise again, and this time nobody doubted that a real epidemic was at hand. The increase was estimated to be 40 percent a year. By 1982 there were thought to be 20,000 heroin users in London alone. Geoffrey Pearson reports that many cities—Glasgow, Liverpool, Manchester, and Sheffield among them—were now experiencing a drug problem that once had been largely confined to London. The problem, again, was supply. The country was being flooded with cheap, high-quality heroin, first from Iran and then from Southeast Asia.

The United States began the 1960s with a much larger number of heroin addicts and probably a bigger at-risk population than was the case in Great Britain. Even though it would be foolhardy to suppose that the British system, if installed here, would have worked the same way or with the same results, it would be equally foolhardy to suppose that a combination of heroin available from leaky clinics and from street dealers who faced only minimal law-enforcement risks would not have produced a much greater increase in heroin use than we actually experienced. My guess is that if we had allowed either doctors or clinics to prescribe heroin, we would have had far worse results than were produced in Britain, if for no other reason than the vastly larger number of addicts with which we began. We would have had to find some way to police thousands (not scores)
of physicians and hundreds (not dozens) of clinics. If the British civil service found it difficult to keep heroin in the hands of addicts and out of the hands of recruits when it was dealing with a few hundred people, how well would the American civil service have accomplished the same tasks when dealing with tens of thousands of people?

BACK TO THE FUTURE

Now cocaine, especially in its potent form, crack, is the focus of attention. Now as in 1972 the government is trying to reduce its use. Now as then some people are advocating legalization. Is there any more reason to yield to those arguments today than there was almost two decades ago?*

I think not. If we had yielded in 1972 we almost certainly would have had today a permanent population of several million, not several hundred thousand, heroin addicts. If we yield now we will have a far more serious problem with cocaine.

Crack is worse than heroin by almost any measure. Heroin produces a pleasant drowsiness and, if hygienically administered, has only the physical side effects of constipation and sexual impotence. Regular heroin use incapacitates many users, especially poor ones, for any productive work or social responsibility. They will sit nodding on a street corner, helpless but at least harmless. By contrast, regular cocaine use leaves the user neither helpless nor harmless. When smoked (as with crack) or injected, cocaine produces instant, intense, and short-lived euphoria. The experience generates a powerful desire to repeat it. If the drug is readily available, repeat use will occur. Those people who progress to “bingeing” on cocaine become devoted to the drug and its effects to the exclusion of almost all other considerations—job, family, children, sleep, food, even sex. Dr. Frank Gawin at Yale and Dr. Everett Ellinwood at Duke report that a substantial percentage of all high-dose, binge users become uninhibited, impulsive, hypersexual, compulsive, irritable, and hyperactive. Their moods vacillate dramatically, leading at times to violence and homicide.

Women are much more likely to use crack than heroin, and if they are pregnant, the effects on their babies are tragic. Douglas Besharov, who has been following the effects of drugs on infants for twenty years, writes that nothing he learned about heroin prepared him for the devastation of cocaine. Cocaine harms the fetus and can lead to physical deformities or neurological damage. Some crack babies have for all practical purposes suffered a disabling stroke while still in the womb. The long-term consequences of this brain damage are lowered cognitive ability and the onset of mood disorders. Besharov estimates that about 30,000 to 50,000 such babies are born every year, about 7,000 in New York City alone. There may be ways to treat such infants, but from everything we now know treatment will be long, difficult, and expensive. Worse, the mothers who are most likely to produce crack babies are precisely the ones who, because of poverty or temperament, are least able and willing to obtain such treatment.

In fact, anecdotal evidence suggest that crack mothers are likely to abuse their infants.*

The notion that abusing drugs such as cocaine is a “victimless crime” is not only absurd but dangerous. Even ignoring the fetal drug syndrome, crack-dependent people are, like heroin addicts, individuals who regularly victimize their children by neglect, their spouses by improvidence, their employers by lethargy, and their coworkers by carelessness. Society is not and could never be a collection of autonomous individuals. We all have a stake in ensuring that each of us displays a minimal level of dignity, responsibility, and empathy. We cannot, of course, coerce people into goodness, but we can and should insist that some standards must be met if society itself—on which the very existence of the human personality depends—is to persist. Drawing the

* I do not take up the question of marijuana. For a variety of reasons—its widespread use and its lesser tendency to addict it presents a different problem from cocaine or heroin.
line that defines those standards is difficult and contentious, but if crack and heroin use do not fall below it, what does... It is possible that some people will not become heavy users even when the drug is readily available in its most potent form. So far there are no scientific grounds for predicting who will and who will not become dependent. Neither socioeconomic background nor personality traits differentiate between casual and intensive users. Thus, the only way to settle the question of who is correct about the effect of easy availability of drug use, Nadelmann or Gawin and Ellinwood, is to try it and see. But that social experiment is so risky as to be no experiment at all, for if cocaine is legalized and if the rate of its abusive use increases dramatically, there is no way to put the genie back in the bottle, and it is not a kindly genie.

HAVE WE LOST?

Many people who agree that there are risks in legalizing cocaine or heroin still favor it because, they think, we have lost the war on drugs. “Nothing we have done has worked” and the current federal policy is just “more of the same.” Whatever the costs of greater drug use, surely they would be less than the costs of our present, failed efforts.

That is exactly what I was told in 1972—and heroin is not quite as bad a drug as cocaine. We did not surrender and we did not lose. We did not win, either. What the nation accomplished then was what most efforts to save people from themselves can accomplish: the problem was contained and the number of victims minimized, all at a considerable cost in law enforcement and increased crime. Was the cost worth it? I think so, but many others may disagree. What are the lives of would-be addicts worth? I recall some people saying to me then, “Let them kill themselves.” I was appalled. Happily, such views did not prevail.

Have we lost today? Not at all. High-rate cocaine use is not commonplace. The National Institute of Drug Abuse (NIDA) reports that less than 5 percent of high-school seniors used cocaine within the last thirty days. Of course this survey misses young people who have dropped out of school and discounts those who lie on the questionnaire, but even if we inflate the NIDA estimate by some plausible percentage, it is still not much above 5 percent. Medical examiners reported in 1987 that about 1,500 died from cocaine use; hospital emergency rooms reported about 30,000 admissions related to cocaine abuse.

These are not small numbers, but neither are they evidence of a nationwide plague that threatens to engulf us all. Moreover, cities vary greatly in the proportion of people who are involved with cocaine. To get city-level data we need to turn to drug tests carried out on arrested persons, who obviously are more likely to be drug users than the average citizen. The National Institute of Justice, through its Drug Use Forecasting (DUF) project, collects urinalysis data on arrestees in 22 cities. As we have already seen, opiate (chiefly heroin) use has been flat or declining in most of these cities over the last decade. Cocaine use has gone up sharply, but with great variation among cities. New York, Philadelphia, and Washington, D.C., all report that two-thirds or more of their arrestees tested positive for cocaine, but in Portland, San Antonio, and Indianapolis, the percentage was one-third less.

In some neighborhoods, of course, matters have reached crisis proportions. Gangs control the streets, shootings terrorize residents, and drug-dealing occurs in plain view. The police seem barely able to contain matters. But in these neighborhoods—unlike at Palo Alto cocktail parties—the people are not calling for legalization, they are calling for help. And often not much help has come. Many cities are willing to do almost anything about the drug problem except spend more money on it. The federal government cannot change that; only local voters and politicians can. It is not clear that they will.

It took ten years to contain heroin. We have had experience with crack for only about three or four years. Each year we spend perhaps
$11 billion on law enforcement (and some of that goes to deal with marijuana) and perhaps $2 billion on treatment. Large sums, but not sums that should lead anyone to say, "We just can't afford this any more."

The illegality of drugs increases crime, partly because some users turn to crime to pay for their habits, partly because some users are stimulated by certain drugs (such as crack or PCP) to act more violently or ruthlessly than they otherwise would, and partly because criminal organizations seeking to control drug supplies use force to manage their markets. These also are serious costs, but no one knows how much they would be reduced if drugs were legalized. Addicts would no longer steal to pay black-market prices for drugs, a real gain. But some, perhaps a great deal, of that gain would be offset by the great increase in the number of addicts. These people, nodding on heroin or living in the delusional high of cocaine, would hardly be ideal employees. Many would steal simply to support themselves, since snatch-and-grab, opportunistic crime can be managed even by people unable to hold a regular job or plan an elaborate crime. Those British addicts who get their supplies from government clinics are not models of law-abiding decency. Most are in crime, and though their per-capita rate of criminality may be lower thanks to the cheapness of their drugs, the total volume of crime they produce may be quite large. Of course, society could decide to support all unemployable addicts on welfare, but that would mean that gains from lowered rates of crime would have to be offset by large increases in welfare budgets.

Proponents of legalization claim that the costs of having more addicts around would be largely if not entirely offset by having more money available with which to treat and care for them. The money would come from the taxes levied on the sale of heroin and cocaine.

To obtain this fiscal dividend, however, legalization’s supporters must first solve an economic dilemma. If they want to raise a lot of money to pay for welfare and treatment, the tax rate on the drugs will have to be quite high. Even if they themselves do not want a high tax rate, the politicians’ love of “sin taxes” would probably guarantee that it would be high anyway. But the higher the tax, the higher the price of the drug, and the higher the price the greater the likelihood that addicts will turn to crime to find the money for it and that criminal organizations will be formed to sell tax-free drugs at below-market rates. If we managed to keep taxes (and thus prices) low, we would get that much less money to pay for welfare and treatment and more people could afford to become addicts. There may be an optimal tax rate for drugs that maximizes revenue while minimizing crime, bootlegging, and the recruitment of new addicts, but our experience with alcohol does not suggest that we know how to find it.

THE BENEFITS OF ILLGALITY

The advocates of legalization find nothing to be said in favor of the current system except, possibly, that it keeps the number of addicts smaller than it would otherwise be. In fact, the benefits are more substantial than that.

First, treatment. All the talk about providing “treatment on demand” implies that there is a demand for treatment. That is not quite right. There are some drug-dependent people who genuinely want treatment and will remain in it if offered, they should receive it. But there are far more who want only short-term help after a bad crash; once stabilized and bathed, they are back on the street again, hustling. And even many of the addicts who enroll in a program honestly wanting help drop out after a short while when they discover that help takes time and commitment. Drug-dependent people have very short time horizons and a weak capacity for commitment. These two groups—those looking for a quick fix and those unable to stick with a long-term fix—are not easily helped. Even if we increase the number of treatment slots—as we should—we would have to do something to make treatment more effective.
One thing that can often make it more effective is compulsion. Douglas Anglin of UCLA, in common with many other researchers, has found that the longer one stays in a treatment program, the better the chances of a reduction in drug dependency. But he, again like most other researchers, has found that drop-out rates are high. He has also found, however, that patients who enter treatment under legal compulsion stay in the program longer than those not subject to such pressure. His research on the California civil-commitment program, for example, found that heroin users involved with its required drug-testing program had over the long term a lower rate of heroin use than similar addicts who were free from such constraints. If for many addicts compulsion is a useful component of treatment, it is not clear how compulsion could be achieved in a society where purchasing, possessing, and using the drug were legal. It could be managed, I suppose, but I would not want to have to answer the challenge from the American Civil Liberties Union that it is wrong to compel a person to undergo treatment for consuming a legal commodity.

Next, education. We are now investing substantially in drug-education programs in the schools. Though we do not yet know for certain what will work, there are some promising leads. But I wonder how credible such programs would be if they were aimed at dissuading children from doing something perfectly legal. We could, of course, treat drug education like smoking education: inhaling crack and inhaling tobacco are both legal, but you should not do it because it is bad for you. That tobacco is bad for you is easily shown; the Surgeon General has seen to that. But what do we say about crack? It is pleasurable, but devoting yourself to so much pleasure is not a good idea (though perfectly legal)? Unlike tobacco, cocaine will not give you cancer or emphysema, but it will lead you to neglect your duties to family, job, and neighborhood? Everybody is doing cocaine, but you should not?

Again, it might be possible under a legalized regime to have effective drug-prevention pro-
grams, but their effectiveness would depend heavily, I think, on first having decided that cocaine use, like tobacco use, is purely a matter of practical consequences; no fundamental moral significance attaches to either. But if we believe—as I do—that dependency on certain mind-altering drugs is a moral issue and their illegality rests in part on their immorality, then legalizing them underrubs, if it does not eliminate altogether, the moral message.

That message is at the root of the distinction we now make between nicotine and cocaine. Both are highly addictive; both have harmful physical effects. But we treat the two drugs differently, not simply because nicotine is so widely used as to be beyond the reach of effective prohibition, but because it does not destroy the user’s essential humanity. Tobacco shortens one’s life, cocaine debases it. Nicotine alters one’s habits, cocaine alters one’s soul. The heavy use of crack, unlike the heavy use of tobacco, corrodes those natural sentiments of sympathy and duty that constitute our human nature and make possible our social life. To say, as does Nadelmann, that distinguishing morally between tobacco and cocaine is “little more than a transient prejudice” is close to saying that morality itself is but a prejudice.

THE ALCOHOL PROBLEM

Now we have arrived where many arguments about legalizing drugs begin: is there any reason to treat heroin and cocaine differently from the way we treat alcohol?

There is no easy answer to that question because, as with so many human problems, one cannot decide simply on the basis of moral principles or of individual consequences; one has to temper any policy by a common-sense judgment of what is possible. Alcohol, like heroin, cocaine, PCP, and marijuana, is a drug—that is, a mood-altering substance—and consumed to excess it certainly has harmful consequences: auto accidents, barroom fights, bedroom shootings. It is also, for some people, addictive. We cannot
confidently compare the addictive powers of these
drugs, but the best evidence suggests that crack
and heroin are much more addictive than alcohol.

Many people, Nadelmann included, argue
that since the health and financial costs of alco-
hol abuse are so much higher than those of
cocaine and heroin abuse, it is hypocrisy to
devote our efforts to preventing cocaine and
drug use. But as Mark Kleiman of Harvard has
pointed out, this comparison is quite mislead-
ing. What Nadelmann is doing is showing that a
*legalized* drug (alcohol) produces greater social
harm than *illegal* ones (cocaine and heroin). But
of course. Suppose that in the 1920s we had
made heroin and cocaine legal and alcohol illegal.
Can anyone doubt that Nadelmann would now
be writing that it is folly to continue our ban on
alcohol because cocaine and heroin are so much
more harmful?

And let there be no doubt about it—wides-
spread heroin and cocaine use are associated
with all manner of ills. Thomas Bewley found
that the mortality rate of British heroin addicts
in 1968 was 28 times as high as the death rate of
the same age group of non-addicts, even though
in England at the time an addict could obtain
free or low-cost heroin and clean needles from
British clinics. Perform the following mental
experiment: suppose we legalize heroin and
cocaine in this country. In what proportion of
auto fatalities would the state police report that
the driver was nodding off on heroin or reck-
lessly driving on a coke high? In what propor-
tion of spouse-assault and child-abuse cases
would the local police report that crack was
involved? In what proportion of industrial acci-
dents would safety investigators report that the
forklift or drillpress operator was in a drug-
induced stupor or frenzy? We do not know exactly
what the proportion would be, but anyone who
asserts that it would not be much higher than it
is now would have to believe that these drugs
have little appeal except when they are illegal.

And that is nonsense.

An advocate of legalization might concede
that social harm—perhaps harm equivalent to
that already produced by alcohol—would follow
from making cocaine and heroin generally avail-
able. But at least, he might add, we would have
the problem “out in the open” where it could
be treated as a matter of “public health.” That is
well and good, if we knew how to treat—that is,
cure—heroin and cocaine abuse. But we do not
know how to do it for all the people who would
need such help. We are having only limited suc-
cess in coping with chronic alcoholics. Addictive
behavior is immensely difficult to change, and
the best methods for changing it—living in
drug-free therapeutic communities, becoming
faithful members of Alcoholics Anonymous or
Narcotics Anonymous—require great personal
commitment, a quality that is, alas, in short
supply among the very persons—young people,
disadvantaged people—who are often most at
risk for addiction.

Suppose that today we had, not 15 million
alcohol abusers, but half a million. Suppose that
we already knew that we have learned from our
long experience with the widespread use of alco-
hol. Would we make whiskey legal? I do not
know, but I suspect there would a lively debate.
The Surgeon General would remind us of the
risks alcohol poses to pregnant women. The
National Highway Traffic Safety Administration
would point out the likelihood of more highway
fatalities caused by drunk drivers. The Food and
Drug Administration might find that there
is a nontrivial increase in cancer associated with
alcohol consumption. At the same time the
police would report great difficulties in keeping
illegal whiskey out of our cities, officers being
corrupted by bootleggers, and alcohol addicts
often resorting to crime to feed their habits.
Liberarians, for their part, would argue that
every citizen has the right to drink anything
he wishes and that drinking is, in any event, a
“victimless crime.”

However the debate might turn out, the cen-
tral fact would be that the problem was still, at
that point, a small one. The government cannot
legislate away the addictive tendencies in all of
us, nor can it remove completely even the most
dangerous addictive substances. But it can cope with harms when the harms are still manageable.

SCIENCE AND ADDICTION

One advantage of containing a problem while it is still containable is that it buys time for science to learn more about it and perhaps discover a cure. Almost unnoticed in the current debate over legalizing drugs is that basic science has made rapid strides in identifying the underlying neurological processes involved in some forms of addiction. Stimulants such as cocaine and amphetamines alter the way certain brain cells communicate with one another. That alteration is complex and not entirely understood, but in simplified form it involves modifying the way in which a neurotransmitter called dopamine sends signals from one cell to another.

When dopamine crosses the synapse between two cells, it is in effect carrying a message from the first cell to activate the second one. In certain parts of the brain that message is experienced as pleasure. After the message is delivered, the dopamine returns to the first cell. Cocaine apparently blocks this return, or “reuptake,” so that the excited cell and others nearby continue to send pleasure messages. When the exaggerated high produced by cocaine-influenced dopamine finally ends, the brain cells may (in ways that are still a matter of dispute) suffer from an extreme lack of dopamine, thereby making the individual unable to experience any pleasure at all. This would explain why cocaine users often feel so depressed after enjoying the drug. Stimulants may also affect the way in which other neurotransmitters, such as serotonin and noradrenaline, operate.

Whatever the exact mechanism may be, once it is identified it becomes possible to use drugs to block either the effect of cocaine or its tendency to produce dependency. There have already been experiments using desipramine, imipramine, bromocriptine, carbamazepine, and other chemicals. There are some promising results.

Tragically, we spend very little on such research, and the agencies funding it have not in the past occupied very influential or visible posts in the federal bureaucracy. If there is one aspect of the “war on drugs” metaphor that I dislike, it is the tendency to focus attention almost exclusively on the troops in the trenches, whether engaged in enforcement or treatment, and away from the research-and-development efforts back on the home front where the war may ultimately be decided.

I believe that the prospects of scientists in controlling addiction will be strongly influenced by the size and character of the problem they face. If the problem is a few hundred thousand chronic high-dose users of an illegal product, the chances of making a difference at a reasonable cost will be much greater than if the problem is a few million chronic users of legal substances. Once a drug is legal, not only will its use increase but many of those who then use it will prefer the drug to the treatment: they will want the pleasure, whatever the cost to themselves or their families, and they will resist—probably successfully—any efforts to wean them away from experiencing the high that comes from inhaling a legal substance.

Review Questions

1. What are Milton Friedman’s arguments for legalizing heroin?
2. According to Wilson, why did the number of new users of heroin decrease from 1970 to 1974?
3. If heroin had been legalized in 1972, what would have happened, in Wilson’s view?
4. Why does Wilson think that crack cocaine is worse than heroin?
5. What is Wilson’s view of the war on drugs?
6. According to Wilson, why should drug treatment be compulsory?