1973

Contemporary Problems of Drug Abuse - III. Saturday Afternoon

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a larger social framework and everytime you start pressing buttons because you think that this is morally justified or it is morally horrendous, recognize that you are turning a policy over and you had better be certain that it conforms with that whole larger area we are talking about.

DR. BRYANT: Thank you.

MR. LEVIN: I would like to thank Dr. Musto, Mr. Sonnenreich, Dr. Bryant, Mr. Leff, Mr. Hughes, Mr. Markham, and Mr. Vanocur.

III. SATURDAY AFTERNOON

A. The Mass Media and Drug Taking

MR. LEVIN: Ladies and gentlemen, the Commission report focused to some degree on the relationship between the mass media and drug abuse. We are fortunate to have with us this afternoon Federal Communications Commissioner Nicholas Johnson, who will discuss this issue with us in detail.

THE HONORABLE NICHOLAS JOHNSON: Good afternoon. There are a few things I want to say at the outset about the problem of radio and television with regard to the drug problem in our country in general, and then I would like to entertain questions and learn the things in which you are interested.

I want, particularly, to address this afternoon the so-called "self-regulatory" effort of the National Association of Broadcasters with regard to drug advertising, something which has not really received much public discussion so far. Then, if we have time, I would like to say something about what I believe to be the real cause of the problem, if any, and what it is we need to do about it.

For starters — and this relates a bit to the broader subject that we may get around to before the afternoon is over — radio and television commercials put forward a particular philosophy, a particular point of view, a particular style of life that is echoed throughout the programs as well as the commercials. It makes no difference, really, what product is being advertised because all commercials are commercials for all products. Moreover, all programs are written by the same people who write the commercials and are paid for by the same people who are likewise pushing the same style of life, the same commercial products, the same values of conspicuous consumption, and the same material gospel.
If you study them, you get a sense of the extent and the degree to which radio and television commercials make a very persuasive case for why we should not try to achieve our full potential as human beings, why we should not pursue the fulfillment of individuality, personal growth, and why we should not attempt to mold a maturity born of confrontation with reality. What radio and television commercials are telling us is that deodorants and soaps and toothpaste and mouthwashes will increase our sexuality; they tell us that we are not supposed to experience our feelings of fear or anger or anything else. They say that there is something dangerously unacceptable about an occasional sleepless night and that our psychic states are solely a function of the chemicals that we ingest. One commercial advises us that the answer to our tension headaches is aspirin with bufferin, and a little later on in the evening the same pharmaceutical company advises us that plain aspirin is really the best remedy. While beer-drinking lulls us into the state of witlessness that is the prerequisite for watching the program — as Nathan Williams has observed, television wants to keep you stupid so that you will watch it — at the same time we are watching these programs the advertisers want us to watch, drinking their product, commercials are telling us that beer is going to give us the gusto to go climb a mountain or engage in some other vigorous pursuit.

Without multiplying the examples endlessly, let me, in short, make the rather obvious point that the drug advertisers are telling us what they and their advertising agencies believe is the best way of promoting their product, getting us to buy it, regardless of our need, regardless of our welfare, regardless of the merit of the product.

There is a sameness about these commercials, even though they are talking about different products, that has helped to produce its own national anxiety. Sometimes the anxiety is related to the program as well. You may notice the number of headache remedies that are advertised during the evening news, as if that were somehow the way to deal with problems that you have just been watching. Uniformly these advertisements heighten our awareness of the tensions of living in what is really a very hostile environment for human beings and for individual growth — a somewhat neurotic society, one might say, a society that is cluttered with the value structure and with the products of the other corporate sponsors. These commercials argue that the fault, the difficulties that we confront as human beings trying to make a life for ourselves in the corporate state that is America today, lie in our failure to adjust to their values, and that the way we may become “normal” is to take the drugs and other mind-altering chemicals that they offer.
Last year the drug industry spent some $400 million trying to get such a message across to the American people. That constitutes some 35 per cent of the wholesale value of the drugs. Of that $400 million, some $300 million was spent on television advertising alone.

The wine and beer industries spent $100 million pushing their products, and those investments have certainly paid off. Americans are spending at least $2 billion a year on their non-prescription drug habit and about $31 billion a year on the nation's number one hard drug by any measure, alcohol.

The problems posed by the broadcast advertising of drugs have not gone totally unnoticed. Public awareness has increased, as evidenced in part by this very conference. Recently on public broadcasting there has been a show called The Advocates, which some of you may have seen. It has a debate format. On the particular evening when I appeared as a witness, the subject was whether or not drug advertising should be banned. After the show, the audience writes in and votes how they feel about the proposition. On that particular evening when the case against a ban on drug advertising was put as forcefully as advocates for that position could put it (of course, the case for a ban on drug advertising was also forcefully put forward) of the audience that participated, who had heard both sides of the argument, 85 per cent said they wanted a ban on drug advertising on television.

The National Council of Churches held extensive hearings on drug advertising and concluded that pharmaceutical ads "encourage the misuse and abuse of drugs."

The President's Commission on Marihuana and Drug Abuse, which you have heard about at this conference from the director of the Commission, also recommended limitations on drug advertising. The Congress has begun to reflect that concern as well. Senator Nelson introduced a bill that would regulate drug advertisements in an effort to prevent deception, and Congressman Claude Pepper has, at least, threatened to introduce a bill that would ban drug advertising during the daytime hours in an effort to help in dealing with the problems of drug advertising to children.

In short, I think that more and more Americans are becoming aware that they are living in a drug culture, one that is fostered by corporate avarice, one that has spawned an ever-increasing barrage of drug messages which encourages us to participate in the chemical life style from which the drug companies profit so handsomely.

There are at least two major problems inherent in the content of the drug ads. I think there is a considerable danger that the constant airing of only one side of this particular question of science, of religion,
of life style, of philosophy, has created a massive problem of misinformation on the part of the American people. Such misinformation is a problem in any society that is premised on democratic principles. It is especially serious when the misinformation happens to relate to the nation's health. Basically — and this is something the medical profession ought to be interested in — the drug advertisements are encouraging people, first of all, to be much more conscious of symptoms than they might otherwise be; to be perhaps unduly concerned about their health. Second, it encourages them to evaluate and note the particular symptoms which they have. Third, it encourages them to diagnose their own ills. And fourth, it then encourages them to prescribe their own pills. Why someone has not thought to bring a malpractice of medicine suit against the drug advertisers, I do not know, but that is essentially what they are engaged in — endeavoring to substitute their television commercials for the counsel of a doctor.

The second major problem is that the drug advertisements, like all other commercials, promote a conspicuous consumption style of life, which has geopolitical implications in international politics, as well as psychological implications. I think, as do a great many other observers, that such advertising bears a major part of the responsibility for the kinds and degree of anxieties that we now see in Americans which have led them to the chemical solutions in the first place. On the one hand, we give advertisers free rein to create an artificial demand for useless or harmful products and at the same time, we limit the right of those opposed to get their message on the air. What you may not know is that the same people who control the programs and the commercials also control the so-called public service spots through the Advertising Council which clears public service announcements for viewing on television. The Council, as you might guess, is made up of the very same fellows who write all the other commercials. That is one reason why the public service spots you see say so very little about so very much.

It is the first problem, that of misinformation, which has spawned the greatest amount of public and congressional criticism so far, but I think the second problem is also now beginning to demand some serious attention. That is the problem that troubles the drug industry the most, because that industry literally thrives on the sorts of anxieties that are inherent in a consumption-oriented society, the kinds of anxieties that come from an individual's feeling of inadequacy because he is not consuming as much as that guy in the commercial. If you notice, virtually all of the commercials and the programs, come to you from the $125,000 homes in which most Americans do not live.
It is always amazing to me that if you just turn on the television at random, you cannot tell, at first glance, whether it is a commercial or a program to which you have tuned. Take the typical Hawaiian beach scene — there is a man and a woman in an automobile on the beach and the waves are coming up on the sand. It may be one of those Hawaiian cops and robbers shows or it may be a commercial, but if it is a commercial there is no telling what it is going to be a commercial for. It may be for the airline that got them there; it may be for the automobile company from which they bought the car or the rental car company from which they rented it, or the hair spray company that provided the lady's hair spray, or the soft drink that is about to come bounding out of the waves. Or take the all-purpose commercial in which the lady walks out into the living room which has expensive drapes, thick carpet, and expensive furniture. She is wearing a long dress and lots of makeup and hair spray. You do not know what she is going to sell you because it could be any one of those things, but then she takes out from behind her back a can of lemon something and sprays it all over. Basically what she is selling you is that $125,000 house and all that goes with it, and she says, "If you are not living this way, you don't amount to anything as a human being and you are unhappy and miserable because you don't have all this stuff that I have got, that I have got to wax and clean and move and dust and get repaired when it breaks."

Well, in any event, that is why the broadcasting and drug industry so fear the prospect of information leaking out to the American people, and so it was that they groped for an instant cure for the congressional anxieties that had begun to reflect public worry about drug advertising. The National Association of Broadcasters' Code Review Board recently presented the public, and more particularly the Congress, with a superficial remedy to the drug advertising problem which was reminiscent of the drug industry's simple-minded remedy of the pill for every ill.

The National Association of Broadcasters, known in Washington as "NAB," has set out to nab the pushers, who turn out to be its own members.

The new rules of the Review Board, the Code, would encourage broadcasters to regulate drug advertisements in a variety of ways. It encourages drug advertisements that provide factual information; it attempts to discourage advertisements that a product will alter the user's mood; it encourages drug advertisers to advise users to read the label. It seeks to prohibit the on-camera taking of pills, the use of children in drug advertisements, drug advertising that is adjacent to

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programs principally designed for children, and personal testimonials by celebrities.

The public ought to be extremely skeptical about this alleged effort at “self-regulation.” First of all, even if these so-called rules were applicable to all stations, which they are not, and meaningfully enforced, which they are not, they are extremely vague and not even designed to correct anything but a small part of the problem.

The thrust of the drug advertisements is not likely to be changed — “Better Living Through Chemistry” is not just a DuPont slogan — nor is there any hope that the new rules will reduce the potential for misinformation inherent in such ads, nor is there any prospect for fewer drug ads, nor is there any hope for information about drugs from a source other than the pusher.

The only real answer to the problem of misinformation is to allow what are called “countercommercials” on radio and television. For example, when a drug commercial says that a particular aspirin product cures headaches faster than any other, the counter-ad might offer the evidence that all aspirin is the same and that the least expensive brand is the best buy. Needless to say, the NAB Code would have nothing to do with a proposal for countercommercials. Indeed, I once engaged the General Counsel of the NAB in a colloquy in a hearing before the Federal Communications Commission (FCC) because Bayer was using the AMA’s report that all these modified analgesics actually do you no more good, and in some instances more harm, than plain aspirin. Bayer, of course, did not use the entire AMA report, it only used the report up to that point and then went on to say that, therefore, one should buy Bayer. A public interest group wanted to take the entire AMA report, which went on to say that if you are buying aspirin you ought to get the cheapest brand, and run that as a public service advertisement. I might add, parenthetically, that the report does not go anywhere near far enough. By my standards, I think the people ought to be told why it is you get headaches, what you can learn from headaches, how you can change your life so that you do not have any, and how massage works better than aspirin when you get one — but that is really a separate subject. In any event, I asked the General Counsel of NAB why it was that he found the ad from Bayer quite acceptable but the ad from the public interest group, using the same information, unacceptable. He responded quite candidly that the public interest group’s commercial would be, in his words, “too credible.” In that regard, I might note that broadcasters are well aware that counteradvertising regarding cigarettes did
far more to reduce the consumption of cigarettes in the United States than the ultimate ban on cigarette advertising.

The reason why the NAB solution cannot deal with the misinformation problem is because it relies, as I indicated, upon the pusher to tell the truth about his product, a belief which I think remains a pipedream. In any event, the Code does not deal at all — and I should say, in fairness, that it never tried to — with the problem of drug orientation in our society, because a resolution of that problem would require either that all sides of the issue be heard or that drug advertising be banned entirely. A system of full information to the consumer has always been an anathema to the American businessman because he is frightened of the effect that intelligent choices in the marketplace might have on his merchandising efforts. Frankly, I have always had more confidence in the American free enterprise system than that. I have never felt it was absolutely necessary to lie, cheat, misrepresent, and otherwise engage in fraudulent practices in order to move your goods. I have always felt that a fully informed consumer would continue to buy the best product in the marketplace; that free market forces would work, and that all the theory of the free enterprise system would prevail. However, as is obvious, it is very difficult to get the business community to support that position.

It might very well be that a ban on drug advertising would increase the profits of drug companies. After all, they have a $300 million investment in advertising. It is interesting to note that the cigarette companies found that Wall Street understood the significance of the cigarette advertising ban and the stock prices shot up, not down. Cigarette consumption has begun to rise once again, now that people are no longer constantly reminded that cigarette smoking is associated with death as well as with sexuality and the other attributes of a fun-packed adult life.

Even if the regulations did offer a solution to the misinformation problem — which they do not — they would still be ineffective. I do not know how many of you have studied the process of so-called self-regulation by American industry, but lest you have any misapprehension about its effectiveness, let me disabuse you of it by describing the situation in the broadcasting industry. In the first place, most broadcasters in America do not even subscribe to the NAB Code. Only 3,000 out of 8,000 radio and television stations do so. Therefore, you have got 5,000 at the outset that are not affected by it at all.

What about the 3,000? First, the Code makes no effort to monitor what they do, so there is no way to report any violations that might
occur, if they did occur. Secondly, if violations were reported, there is no method of factfinding or hearing procedure which could be utilized to determine what the broadcaster actually did. Even if there were such investigatory procedures available there is still no procedure for the enforcement of the regulations and there are no penalties attached to a violation. It is not surprising that, therefore, I conclude that the NAB, as a protector of the public interest, is scarcely even a paper tiger.

The only bodies that could enforce rules against drug advertising are the FCC and the Congress — and they will not. The FCC has simply abdicated its responsibility in this area, as I should say it has in so many others. The Congress, which once appeared concerned about the problem, has now been mollified by the broadcasters’ superficial proposal of self-regulation. Congressman Paul Rogers, Chairman of the House Public Health and Environment Subcommittee, has commended the broadcast industry for its new rules. He has said that “certainly this is a preferable way to handle matters, to let industry regulate itself where possible.” And so it would appear that the NAB has, indeed, scored a major public relations coup. The Congress has cooled considerably in its attempts to do something about the still very serious problem of drug advertising. Congressman Pepper has yet to introduce that bill which he has been threatening to introduce for the last 2 or 3 months.

The advertising, drug, and broadcasting industries have taken the pressure off of the Congress and as Broadcasting magazine (the lowest common intellectual denominator for the industry) has characterized it, “We have headed them off at the pass.”

What is disturbing about all of this is that these industries appear to have achieved their goal at such a very modest cost, with so insignificant a gesture, which is simply another indication of how powerful they really are. My only hope, which I retain with my seemingly unquenchable optimism, is that the American people will not be fooled so easily in this day of shell games from Washington. In the final analysis, it is the people who do have some power to effect a change in drug advertising, but only if they will exercise that power, only if they will let their elected representatives in the House and Senate know that they, as well as the drug companies, intend to be heard on this issue. They must let their representatives know that they do not believe the issue has gone away simply because the NAB has come up with a superficial, quick, fast, fast relief remedy in the form of its own Code. I think that once elected representatives begin to
understand that people do care about this issue, that they are going to hold them accountable on it, we may get a fair shake.

Thus endeth the reading for today, and I will turn now to whatever questions you may have.

PARTICIPANT: Have you seen a list of the sponsors of this symposium?

MR. JOHNSON: Yes, I have.

SAME PARTICIPANT: Would you care to comment?

MR. JOHNSON: Yes. The first comment is that I noted the list of sponsors. I am always very interested in where the money is coming from, because I find that there tends to be some correlation between the money that comes in and the result that comes out. I find the best way to deal with that is just not to take any of their money and thereby retain as much independence as you have. I think it is simply another indication of the far-reaching power of these industries, that even when we get together to discuss the problem, we go to them for money and those who expect to go back and get money again obviously are going to be affected in some degree by what they say during the course of the conference — I think that is too bad. But then, that is the great American way and there is a lot right with America. I am tired of those folks that are always criticizing everything!

PARTICIPANT: Would you explain why you have said the FCC has abdicated its responsibilities, and maybe talk about why and how it has done this?

MR. JOHNSON: The question is how and why has the FCC abdicated its responsibilities. The how is very easy. It just does not do anything. The why is more interesting. I do not know how much time you have to spend on this and do not want to go into a whole long rap on it, but most governmental agencies, in fact, are carrying out industry’s wishes rather than being engaged in any meaningful form of regulation. That is an overgeneralization, but it is basically accurate. (If I could talk for 60 minutes about it, you could conclude it was an understatement rather than an overstatement.) This comes about for a number of reasons. You know, we are concerned in this country about inflation right now and we wonder what the cause of it is, why we have the problem. Let me give you some examples of why. You may recall that prior to the presidential election the Department of Agriculture announced that under no circumstances would it raise the price of milk because milk was a basic American commodity and
there was no justification for raising the price because everyone was adequately compensated. One week later some milk producers from the Midwest paid a little call on Richard Nixon and, because of their great support of his political philosophy, decided to leave behind when they walked out of his office a brown paper bag with $325,000 in cash it in. Mysteriously, the very next day, the Department of Agriculture met just on their own to think again about their decision about the rise in the price of milk and concluded, much to everyone's surprise, that they had indeed erred the first time when they considered the subject and that probably a $700 million price rise would be in order.

This is roughly the formula — a 2,000 to one return for what you give in cash to what you get back. The way you get it back is in the variety of ways that government can give it back to you. They can give it back to you by raising the prices to consumers — that is the way we do it in regulatory commissions. Seriously, in the 1970 election the national gas industry gave $700,000. After the election the price of gas was raised $1.5 billion. That is again 2,000 to one. I do not know how much they gave me in 1972, I have not put together the figures yet, but I do know that the day after the election the price of natural gas was raised once again very substantially and that there was immediate talk of an energy crisis. You know the energy crisis. Well, the energy crisis suddenly came up, without any warning, and suddenly we discovered that we have no energy anymore. The remedy for that, which has been widely talked about by those in government and industry (they seem to agree on this) is that the greatest way to produce more natural gas would be to raise the price at the wellhead from 26 cents to 50 cents, thereby doubling everyone's natural gas public utility bill and providing more incentive to drill for that gas.

The FCC at least had enough style to wait and not do anything the day after the election. We waited until Thanksgiving Eve — which gave me an opportunity to comment upon our celebration of holidays in the FCC. Last Christmas we announced that we were simply going to call off entirely a rate hearing regarding the Bell System on the grounds that we did not have enough people to conduct it, which prompted me to write an article entitled, *Why Ma Bell Still Believes in Santa Claus*. Three weeks later the Commission reversed itself and the hearing was reinstated. But on Thanksgiving Eve, long after the press had gone home so that there would be no coverage of it in the papers over the holiday (which is the principal reason why all the times that we really do the worst damage to the public we
announce it after 5 p.m. on Friday or the evening before a holiday), we announced to AT&T that they could have a $1.3 billion increase in telephone rates, an increase which I might note was found to be unjustified by the FCC trial staff, was found to be unjustified by the Hearing Examiner who heard the case, and was found to be unjustified by me and my staff when we reviewed the records. In all probability the increase would never have been able to pass the standards of the Price Commission under Phase II. Thus, the Administration was faced with the embarrassing problem of how to give Bell $1.3 billion when to do so directly violated the standards of its own Price Commission. Those of you who follow these things may recall how the great dilemma was resolved. The Price Commission was abolished, and the $1.3 billion rate increase went into effect.

The price of gasoline is another example. We have had a program known as the Oil Import Quota System. The Oil Import Quota System is designed to keep us from using foreign oil and to encourage the use of our own oil reserves for national defense purposes. At least, that is the way it was explained to me by the companies. Obviously, however, in time, we will have used up our own reserves and will have to rely upon imports. Anyway, this national defense program has resulted in our keeping out of the United States tremendous quantities of foreign oil with the result that we have kept prices of American oil significantly higher than they might otherwise have been — in fact, approximately $7 billion a year, roughly 5 cents per gallon on every gallon of gasoline you buy.

Nixon treated the recommendations of the Commission on the Oil Import Quota Program in much the same way he treated the recommendations of the National Commission on Marihuana and Drug Abuse. The Commission was comprised of economists who had formerly worked for President Eisenhower. They recommended abolition of the Oil Import Quota Program on the grounds that there was no economic justification for it whatsoever. President Nixon promptly ignored their recommendation, kept the Oil Import Quota Program, and kept the cash that came from the oil companies.

In addition to the $7 billion a year paid to the oil companies through the Oil Import Quota Program, there is another sum of like magnitude which is paid to oil companies in the form of welfare payments — taxes that you pay to make up for the taxes that they do not pay. The oil industry during the 1960's paid an average rate of return on income of 5 per cent, although the law, as you may know, requires of all corporations an income tax level of 48 to 50 per cent. Atlantic
Richfield pulled in some $300 to $400 million during a 3 to 4 year period during which it paid zero in income taxes. These are just some of the ways in which your government represents your interest.

The Civil Aeronautics Board (CAB) sees to it that the airlines' rates are regulated in the public interest. Recently you may have seen that the airlines themselves wanted to lower the rates and the CAB would not let them. That is an indication of how far things have gone with that regulatory commission.

In the State of California, where the CAB cannot get its hooks on the airline that runs from San Francisco to Los Angeles, you pay 4 cents a mile to fly. On the East coast, you pay 11 cents because the CAB is representing your interests. You wonder why we have inflation — we elected inflation!

PARTICIPANT: How long have you been Commissioner and how long do you expect to be with the FCC?

MR. JOHNSON: The question is whether the locks are being changed on my door at the office as yet. The answer is that an FCC Commissioner gets a 7-year term. Mine began in 1966 and expires in another 90 days, and after that "You won't have Nick Johnson to kick around anymore."

PARTICIPANT: Would you comment about advertising in medical journals?

MR. JOHNSON: I can. What would you like me to say?

SAME PARTICIPANT: Whether you approve of them.

MR. JOHNSON: I do not read the medical journals regularly, but I understand that they are full of drug advertising and that the drug industry spends approximately $5,000 per doctor encouraging them to prescribe drugs. Is that right? That seems to me to be rather excessive. Think of the medical care programs you could have in this country if you would take $5,000 per doctor and spend it on taking care of people instead of drug advertising.

There was a poll I saw recently, I think it was done among doctors in Boston, and I believe that some 80 per cent of those polled felt that doctors were overprescribing drugs.

I think, by and large, the medical profession — and it is up to doctors to speak to this, not me, but doctors have said essentially what I am repeating — has the same kind of information problem about drugs that the public has. They are overburdened; there is a limit to how many of the thousands and thousands of research reports that
come out every year they can read, and to the extent that their mind gets cluttered up with what they read in a full-page ad in a journal somewhere, it makes it more difficult to get factual information from any direction — a tremendous advantage to the drug companies in pushing their products. Our drug problem exists on many levels. The so-called drug problem and the over-the-counter problem are not the only ramifications of this. It is also present with the prescribed medicines.

Let me note — let me take the time to make this little pitch — that whenever you use, not just a chemical but a product of any kind, whether it is prescribed or not you effect yourself psychologically. It makes you less of a person. It says that you cannot deal with your own problem. You have got to go to an authority figure; you have got to go to something outside of yourself to deal with it. Who you are and what you are is a function of how you look, what products you associate yourself with. We can see this throughout alcohol consumption patterns. People choose what they drink based on their image of self and the image they wish to project. People choose cigarettes on the same basis. They choose a whole range of products on that basis.

I am not trying to say that under no circumstance should you use any medicine, do not put me in that box. But I am saying that when you prescribe medicine, either as a doctor, or when you prescribe it for yourself as a patient by over–the–counter drugs, or when you get into other drugs like alcohol, basically you are getting away from yourself rather than into yourself. You are weakening your own self-hood and are retard ing your own striving toward a sense of potential and fulfillment because you are saying that you cannot deal with whatever problem you may have by yourself. This is one of the reasons why one of the most effective approaches to drug abuse that have come along have been things like the Maharishi transcendental meditation and Yogi Bajan’s yoga, etc., because those things do help. I am not pushing that, either, but I want to say something about it. Those approaches say look inside of yourself, there is something very special about you as a human being. They say that you are functioning in about 5 per cent of your capacity as a human being — your capacity to love, your capacity to be productive, your capacity for physical health and energy and vigor, your capacity to be creative in an artistic sense. You are functioning in about 5 per cent of your potential and however you want to express it, whether you want to use the language of religion or of psychiatry, or whatever language you want to use to talk about this, there is something very special about you which needs to have a chance to flower, to develop and grow. That is why I would
much rather see somebody deal with a problem of stress and tension by using meditation than by using aspirin, not just because the aspirin may be chemically harmful in some way, but because the aspirin is cutting you off from something you need to know about yourself.

There is nothing wrong with feeling pain. Pain is a way of finding out what is going on inside of you. There are a lot of things you need to feel pain about in order to get from here to there — I mean, there is a reason for it — and if you feel angry or upset or jealous or frustrated, whatever you are down about, whatever you feel, feel that feeling and try to understand it and try to understand where it is coming from. Do not cut your body off at the neck so that you do not understand what is going on inside your body. You need to know what is going on there, and to the extent that you can deal with those things yourself — and again I emphasize I am not saying that under no circumstances should you take medicine; what I am saying is that anytime you can deal with a problem by jogging and getting more oxygen into your brain, by massage, by meditation, by something that you do yourself, by nutrition, by getting more and better sleep, fresh air — there are just tremendous advantages to you as a human being in terms of finding out who the hell you are, what you can do, and what you are all about.

That is the principal thing that is wrong, in my judgment. After you scrape away all the rest of this rhetoric and all these reports and everything else, that is the core of what is really wrong with our reliance upon things external to ourselves. What I am saying applies just as much to buying that Mustang automobile as it applies to Bayer Aspirin, mouthwash, hard drugs like alcohol, or some of the less popular hard drugs. You see, what I am talking about is a whole pattern of behavior that is being forced down upon you by corporations that profit from it. They need to manipulate you. They need to deprive you of your own individuality and worth and strength and striving as a human being. They need to treat you as a mass. They need to keep you watching television. They need you to consume their products. They need to develop your anxieties and tensions and sense of inferiority and worthlessness. They need to develop your sense of being a member of a mob and not being anything.

Jesse Jackson stands before his assembled group in Chicago every Saturday morning and starts off his marvelous performance of combination church service, lecture, music, community meeting, news, and whatever all it is, with a chant: “I am somebody.” And they repeat that back. I think all of us need a little bit of that, not just those poor Blacks who are beaten to death in the kind of life that they have in
that part of Chicago where they are living. All of us need to remind ourselves, "I am somebody."

Television is trying to beat that out of you, and the drug companies are trying to beat that out of you. In my judgment, to talk about the drug problem as we do makes both too much and too little out of it. It is part of a much broader, much more pervasive, much more venal, much more serious, much more debilitating problem as we today watch the decline and fall of the American empire.

Thank you.

[At this point in the program the Streetcorner Society of East Lansing, Michigan, presented "The Street People Look at Our Drug Hypocritical Society."]

B. Do Solutions to Drug Problems Threaten Our Civil Liberties?

MR. LEVIN: We have a most distinguished panel to discuss the question of whether solutions to drug problems threaten our civil liberties. Mark L. Cohen of the Drug Abuse Council in Washington, D. C., will preside.

MR. MARK L. COHEN: I would like first to introduce the members of the panel. Professor Nicholas Kittrie is Professor of Law and Director of the Institute for Studies in Justice and Social Behavior at the American University Law School, and I believe he has just published a book called The Right to be Different.

Dr. Thomas Szasz is Professor of Psychiatry at the Upstate Medical Center of the State University of New York, and his new book is called Second Sin. That is one of many. I think the book he is best known for is Law, Liberty, and Psychiatry.

Dr. Henry Brill is the Director of the Pilgrim State Hospital in New York. He was the Vice Chairman of the Narcotic Addiction and Control Commission in New York State, and also is one of the members of the Commission on Marihuana and Drug Abuse which has just submitted its report to the President, which you heard about this morning from Mike Sonnenreich.

Joe Moss is an Assistant District Attorney in Houston and is the Chief of the Appellate Division of the Criminal Section there. Also, I believe, he has been a television celebrity on the Dick Cavett Show at times.

This afternoon we are going to be talking about civil liberties issues. Of course it is really hard to know what you mean by civil liberties. People have different concepts of what they are. I think
that one way of looking at the problems, without trying to define “civil liberties,” is by raising some issues which I think people ought to be thinking about. One way to start is to consider the fact that liberals look at the civil liberties problem in a kind of interesting way. They see measures taken against addicts as a beginning step towards locking the door on addicts, throwing the key away, and writing them off as viable members of society. They always are interested in the kind of slippery slope concept which says that if you start just a little bit with one deviant group, you start to move toward a totalitarian state, that every measure proposed has civil liberties implications if it has something to do with the exercise of controls over addicts.

Conservatives, on the other hand, see all the fuss that liberals make about civil liberties as a way of undermining, neutralizing, or nullifying any of the good programs that are proposed to control addicts or provide treatment and rehabilitation for them. They see the liberal reaction as a great big fuss over nothing that if taken too seriously, will destroy the ability of the programs to do very much.

The kinds of proposals that are coming out of the Administration in Washington, such as preventive detention and mandatory minimum sentences, obviously have civil liberties implications and I hope that we will be talking about those kinds of things. I am sure you are aware of the fact that the bill in New York proposed by Governor Rockefeller talks about mandatory minimums, doing away with plea bargaining, and doing away with the right to probation and parole for narcotic drug offenders, particularly sellers of drugs. The civil liberties implications of those things, I think, are clear.

There are two issues that I would like to ask the panel to consider: (1) the current policies that are being proposed, and (2) the political and philosophical justification for those policies.

As a kind of editorial comment, I think the general trend is to attempt to stop drug use and to stop people who use drugs from continuing to do so. I think that the justifications for that have to be examined before we look at particular policy issues.

Sometimes the policy questions are affected by certain assumptions. One assumption, for example, is the fact that heroin addiction causes criminal activity. Some of these assumptions have not been tested until very recently; some of them have not been called into question at all.

For awhile, in the middle 1960’s, liberals were saying, “All we have to do is decriminalize drug possession and we will not have a crime problem any longer, since the price of drugs is artificially high.” At the Drug Abuse Council we presented a report to show that the
drugs would cost actually very little, something like 23 cents, to support the habit of a narcotics addict, and that it is the law enforcement effort that drives the price up and is responsible for the accompanying rise in crime rate.

Conservative politicians and law enforcement officials dismissed that out of hand until recently. In 1968 there was a presidential campaign in which the key issue was law and order. Yet, over the ensuing four years it looked as if nothing was happening to stop the rising crime rate. Just before the next election some of the officials who were vulnerable on the point of crime started talking about a solution they had — treat and rehabilitate narcotics addicts, exercise controls over them, and thereby stop the crime problem. A billion dollars were put into the Special Action Office and the goal was to get narcotics addicts into treatment.

One of the things that I think happened was that the President was able to say that we were on the 10-yard line in our fight against crime because we had come up with the idea that drug addiction caused crime. I do not know which 10-yard line he was actually talking about.

MR. MOSS: Or which hash mark.

MR. COHEN: Let me now just talk about what I have referred to as the philosophical bases for a lot of drug policies and raise some questions that I hope will bring to light how we look at some of the issues. The questions I would like to pose are: (1) Are addicts dangerous to themselves, to the community in which they live, and to society in general? (2) Do current policies achieve the purpose of ameliorating whatever real harm results from drug misuse? (3) Is the emphasis on the distinction between the medical and nonmedical drug user misplaced and overemphasized? (4) Is it a mistake to believe addicts ever enter treatment programs voluntarily, or without involuntary commitment? A related question is, does the fact of a law enforcement effort against drug supply and drug users have the effect of driving addicts to treatment? Officials in the Soviet Union have reported that only 3 per cent of the people in mental hospitals were involuntarily committed. We can see that even without action taken through involuntary petition commitment against drug addicts, there are lots of other ways in which coercion may take place. (5) To what extent are policies aimed at the drug problem a part of the general repression in the United States against deviants, people considered to be undesirable?
I want to try to relate those basic problems to the specific policy issues which now confront policy-makers and legislators. Those issues, as I see them, are: (1) mandatory minimum penalties, as I pointed out; (2) urinalysis to detect drugs among school children (a policy that has already gone into effect in the military); (3) pre-trial preventive detention of drug law violators (somebody charged with a drug crime then would not have the right to bail; he would not get out in the community unless he could show that he would not be dangerous and there was not a risk of life); (4) involuntary commitment, not to an institution but to a drug program, which could be an outpatient methadone maintenance program (there has been general disillusionment with involuntary commitment to institutions because it costs too much and nobody really thinks it accomplishes very much for those addicts); (5) confidentiality of records. (What is the role of the psychiatrist or treating physician with respect to the criminal justice authorities who are looking to get at an addict if they think he has committed a crime — do they have to divulge the information that has been communicated in confidence in the physician-patient relationship?); and (6) criminal justice diversion. Ordinarily this latter issue is not thought of as a civil liberties problem. Dr. Jaffe and Mike Sonnenreich mentioned this as a recommendation. The current trend is to take people charged with drug crimes and, instead of prosecuting them or sentencing them, refer them into a drug treatment program. One of the reasons why I think this is a civil liberties problem is that, of people charged with certain crimes, only 20 to 25 per cent really are ever locked up in jail. It is a major problem of the criminal justice system to know what to do with the 70 to 75 per cent left over. If you put them on probation, that does not really mean very much. If you have the medical community taking the responsibility of providing treatment if they live by certain rules, then it becomes a form of involuntary commitment if they are people who otherwise would not be locked up because you do not have the jail space or you do not have the resources to do it. It would cost too much to lock up everybody, so you take people who ordinarily would not be locked up and you refer them to a treatment program.

I would like to call upon Professor Kittrie to give some opening remarks and then we will try to have an interaction where people can ask one another questions.

PROFESSOR KITTRIE: The topic I would like to discuss here by way of introduction to this panel is the right to be or not to be a drug user. I think it is important that we see what we are discussing
here in some perspective, and I think the perspective is really the perspective of the pursuit of happiness.

It has been said of the pursuit of happiness that it is a particularly human characteristic. Other beings are not concerned with a state of happiness. The question is, how far a man may go in selecting what he considers to be his particular state of happiness. May he pursue only the search that we determine for him or may he define his happiness in such terms that might cause us to view him as deviant?

The second point I would like to make is not the right to pursue happiness in any way you want, but the right of a citizen to be told the truth. I am afraid that the drug field is the field of the Big Lie. We have been told lies for a long period of time and I think the question is, to what extent an enlightened citizenry is entitled to be told what the facts really are. Let me give you a few illustrations of what I mean by the Big Lie. It used to be that the government's policy was to demonstrate that the number of addicts was going down. In 1960, the United States government officially sent a report to the United Nations Commission which said that as a result of our drug laws, which were characterized as being very effective, we had a small number of addicts. In fact, we used to say that before the drug laws came into being — as you know, we were a country without prohibitions of narcotics laws until 1914 — we had a million addicts. But now that we have strict narcotics laws we claim to have only 45,000 addicts. Subsequently, the policy changed. Now it fits the government policy to say that there is a tremendous increase in drugs and the use of drugs. We are told that there were at least 700,000 GI's who were using drugs in Vietnam. Now we are building a tremendous machine and I am asking which is the truth. Do these severe laws actually serve to cut down the use of narcotics or are they ineffective? I would like to know what the truth is.

I also found, with great amazement, that we enact drug laws in this country without knowing what the facts are. All you have to do is examine the hearings of the committee which decided to pass the marihuana laws. You will discover that the Senate Committee held hearings which, while lasting about 5 days in total length, could have been compressed in 1½ days. On the basis of that a law was passed which resulted in the criminalization of great segments of our society. So the question is, what is the truth and can we get to that truth.

I would like to raise another issue regarding narcotics in this society. I am somewhat unhappy and distressed that we do not have a larger audience here of Blacks and Chicanos and that we do not have
them on the panel. Let me tell you why I am concerned. There is a growing attempt on the part of some elements in our society to drive a wedge between some of these so-called deprived socioeconomic groups and American liberals. When Governor Rockefeller came up with his strong recommendations pertaining to drugs the liberals were the ones who cried out against them because they saw that as an invasion of privacy. But go and talk to the people in the ghettos. They are not even satisfied with what he wants to do. Some would like to have public executions. I am suggesting to you that there is a real need for the liberals and some representatives of the communities where drug use is rampant to discuss these problems. It may very well be that in the Chicano and in the Black communities, government efforts to control some of these substances may be taken as very promising. Yet those steps could very well be steps towards abuse.

This is not unlike the conflict you may have in the Black community regarding birth control. Some may view birth control as genocide and some may take the position that birth control is essential in order to improve the Blacks' lot sufficiently so that they can be a strong community. It is not the total number of children that is important to a minority. The important question is how many children are to be brought up and what role they will have in society. I would suggest to you that the same discussions regarding drug policies are very important.

I would like to talk about the situation pertaining to use of drugs and say that I am not a liberal on this matter. I am not going to discuss it from a point of view that will enable you to say that I am either soft on drug addicts as such, or that I am strong on law and order. I would like to talk about it strictly from the point of view of social defense. I would submit to you that in areas where definite need for social defense is demonstrated to me, I am perfectly willing to be as hard as nails. I teach criminal law. If somebody would ask me whether I agreed that the repeated rapist should be castrated, I would say, "Why not?" But when it comes to the drug addict, I do not see the need, I do not see the reason for social defense. I submit to you that we are dealing with behavior that criminal law has very little need to regulate. In fact much of our concern in this field is the arbitrary creation of an illegal black market in narcotics which has made it very profitable for some people to derive great benefits at a great cost to society.

I would like to suggest to you that if you want to look rationally at criminal justice and ask, what the proper limits on criminal sanctions are, when we should use them and when we should not, there
are probably four major tests you would like to apply. One is, what is the type and the degree of the social harm? What, precisely, is the social harm presented by narcotics or by marihuana? You could consider the fear that there is a public danger, but, as you well know, the major danger posed by users is when they go out to seek money to buy narcotics that they cannot get in any other way. You might take the position that narcotics produce people who will rely on welfare, increase the number of lazy bums in society. But I doubt whether that justifies stiff criminal sanction. Or you may say that we need to engage in criminal controls of narcotics because we are our brother's keeper, that brotherly love requires that we not allow anybody to go that terrible route. I would like to suggest to you that I am very much in doubt that we want to use criminal law to enforce brotherly love.

The second test for rational policy regarding criminal sanctions ought to be a consideration of the side effects which would flow from the use of criminal sanctions. How adverse would those side effects be? I suggest that the side effects produced by regulation of marihuana and narcotics are terrible. Basically that is a field which others have labeled as a kind of victimless crime. That does not mean that there are not people who suffer from it, but it is usually the person who uses drugs who is likely to be the main victim and he is not about to inform against himself. So, it is an area of victimless crime in which you usually end up with wiretapping, government informers, entrapment, and other forms of criminal enforcement which we do not like. One of the adverse side effects is that we take people who may be harming themselves, and we label them for life. An ex-drug addict finds it more difficult to get employment than an ex-offender.

The next question for rational policy ought to be: Can the criminal law be effective? If the criminal law cannot be effective, then we ought to consider whether we want to use it at all. I suggest that in this field there is too much profit for criminal law to be effective. There is, also, too great a supply of narcotics for criminal law to be effective.

For example, the world production of opium amounts to 1,400 tons a year. It takes only about 5 tons to supply all the needs of the United States. That means we need only one-third of 1 per cent of the world production to satisfy our drug addicts. Therefore, even if you eliminate 90 per cent of the supply, you cannot control it. When there is that much profit, the little amount required to supply the American addicts will continue trickling in.
Some may say criminal sanctions in this field do not work because the sanctions are too weak. It has been said that in New York City only 2 per cent of those arrested for drug felonies go to prison. Do you want to turn around and say that we will get a big percentage of all the drug addicts into prison? I want to warn you that the total number of spaces in our prisons amounts to 250,000. That is the total number of places we have in prisons, and yet the National Commission on Marihuana and Drug Abuse tells us that two million people in the country have used heroin. It tells us that four and a half million people use cocaine. Do you want to get them all into prisons, or only the pushers — and who is not a pusher?

Studies definitely indicate how confused we are about the pusher. We think of the pusher as a fellow from the big city who goes to a nice little village and pushes; but the pusher is your friend. That is the truth. It is somebody you know who offered you that drug the first time. The pushers are just people that we know. If we want to put them all into prison, we are going to fill the prisons; and if we want life sentences, then I would submit to you that if we need to keep them in prison, we might as well execute them all. There is no need to keep people in prison for 30 or 40 years at the cost that is involved. If we are really concerned that the danger and hazard is all that big, let us have the executions.

The fourth consideration should be whether there are other tools that are more effective than criminal sanctions, and whether there are some other tools that are more suited. The tools other than criminalization and strict criminal sanctions have been the following: (1) civil commitments for therapy (I have great difficulties with that because the cures are not easy and the cost is very high); (2) drug maintenance (when I talk about drug maintenance I do not mean legalization — I am talking about a government monopoly, where the government sells drugs to those that need them under certain controls); (3) leave drug addicts completely alone and allow a free market in drugs.

I guess my own feeling is that as long as there is a doubt, as long as there is a question about the hazards caused by drugs, I would not go to the last option of just having free traffic, but I would certainly favor a proposal to allow drug maintenance for people who will pay for it. I do not think they should get it for nothing. We do not get alcohol for nothing. There ought to be a kind of reasonable government price — make a little profit and use the rest for rehabilitation.

At this point, I pass.
MR. COHEN: Mr. Moss, I will ask you to respond point by point.

MR. JOE MOSS: I was assuring myself when I came to this hallowed hall that I would find two or three generation gaps between you and me and, alas, I find I am wrong. Either you have grown old or I have grown young. I am pretty well in agreement with you.

I am of that fast diminishing breed that grew up in the days of federal prohibition, having to satisfy my wants drinking slop. All the things that I have heard year after year and day after day about drugs, I heard back then, all summed up in that phrase: Down with Demon Rum.

Well, Demon Rum went down, so they thought, but they did not know me and they did not know some of my playmates who now are corporate presidents, or whatever.

I have cast my lot the last few years in what I choose to call a state of semi-retirement. Most of my colleagues have gone; I think last week cleaned out the last of them. I am the last survivor of a fast diminishing breed and have gone to the District Attorney in the hopes that I might enjoy once again that thrill that comes with marching down the street on a beautiful spring morning shoulder to shoulder with some buxom prostitute on the way to the local assize to defend her for having administered poison to her pimp or some policeman. It exudes a wonderful feeling to know that there is a defense of those accused of crime. You are performing a task in defense of God's noblest commodity, flesh. While up on the hill, as we called it in the past, are those in the ivory tower who are in the more honorable practice of law, that of defrauding women and children, teaching people how to evade their income tax, putting the small return into mortgages — all those honorable pursuits.

Today I rejoice to say that in my latter days I am proud of the career I have had in criminal law, about two-thirds of which was on the defense side of the docket. Now I have turned honest, shall we say, and I am in the District Attorney's office. My job is to handle all of the cases in the appellate courts, or more equitably stated, my section of the office is to do that.

I want to assure you, at the beginning, that I am an arch conservative. There is no human on the face of this earth, there is not a liberal that ever lived who has embraced the fundamental concept of liberty and freedom any more than an arch conservative. That is one thing in which he believes: "By God, leave me alone!" I go all the way with the recent decisions about civil rights — Mapp v. Ohio,19 Sibron

v. New York,20 Wong Sun v. United States,21 Davis v. Mississippi,22 Pate v. Robinson,23 and all others that keep me out of your house, because they also keep you the hell out of mine.

With the possible exception of the manner in which we of this cesspool of buckpassing known as democracy are handling our juveniles, there is no human on earth being mistreated more by the law in this country than those who are associated in some fashion with drugs, and by that I mean from top to bottom — those that grow it, import it, transport it, synthesize it, advertise it, sell it, push it, use it, do with and do without it, including the physician, the legitimate one and the illegitimate one.

Incidentally, back in the 1930's when they passed the Harrison Act,24 the people that were first prosecuted were doctors. It was not until later that we got around to the more civilized people and started prosecuting them.

Professor Kittrie touched on the aspects of civil rights very adequately when he talked about the odious apparel we have to use in the way of informers, entrapment, and things of that nature in order to enforce our drug laws. I do not enjoy the clang of penitentiary doors on my fellow citizens and I never did enjoy the stench of scorched flesh in the electric chair. I am a strong believer in liberty and if there is anything in the world that I can do to maintain liberty for anyone, I will do it, and I have that authority under our law. No one can order me around except the District Attorney, and he won't. I have no trouble; there is no combination of powers on the face of this globe that can tell me anything about whom or what to prosecute. My problem is to try to satisfy myself as to whom or what not to prosecute. It is very easy to know whom to go after. It is pretty hard to decide whom not to go after.

We are mistreating the people in the drug business because our laws are not uniform. Whatever laws we are going to have, they should be made uniform. If I spit on the sidewalk in Philadelphia I ought to be punished the same as if I spit on it in Houston, and I presume it is just as bad and obnoxious here as it is there, or vice versa. And so it should be with murder, with rape, with thievery, anything else, and particularly with drugs. Unfortunately none of us here is in a position to do anything about that. The making of laws often entails the process of buckpassing by people who quite often

are not attorneys. You can ask one of our legislators about dope or what to do with a narcotics addict or a pusher, or somebody, and he will give you the gobbledygook that we need to get the dope into the hands of legitimate physicians who can use it for a blessing to mankind and that we need to keep it away from the pusher who is giving it to our little children. Just what would he mean and just what would he know?

I would like to end by saying that we can draw on our own experiences and that we should agree on a few things. One thing I believe we can all agree on, without exception, is that the most dangerous thing God gave us on this earth is fire. We learned early that it is dangerous and we must leave it alone unless we know how to handle it. It has caused more destruction, more heartaches, more sorrow than any other element He gave us. On the other hand, it has brought us comfort, satisfaction, and has even sent us to the moon, simply because we learned how to use it and what to do with it. In short, we were educated to its use, we made preparations to use it, and we have used it to our advantage and to our glorification, shall we say. I do not know why we can not do the same thing with any other element. In short, I think the solution to the drug problem, like any other human problem, is 99 per cent education. I do not think we are ever going to be able to do anything with it by law any more than we were ever able to do with alcohol by law. In short, “Very little law is very good law.”

MR. COHEN: As you see, the Assistant District Attorney is on my far right. I tried to figure out a way to take Dr. Szasz and Professor Kittrie and put them on the extreme left. I could not do that, but I would like to introduce Dr. Szasz anyway and see how he responds to the far right.

DOCTOR THOMAS S. SZASZ: I do not know how I can respond to that. That is a hard act to follow, especially since this audience has to switch from a Houston accent to a Budapest accent.

Partly because I have a statement, I would like to read it, instead of responding exactly to Mr. Moss at this time. My statement was not prepared for this occasion, but it fits in a very brief space of time and states my views on this issue. It will take only a few minutes, and then perhaps I can express myself more informally.

In my view, in a free society, all drugs, regardless of their dangerousness, should be legalized. I favor free trade in drugs for the same reasons the founding fathers favored free trade in ideas. As in an open society it is none of the government’s business what idea a
person puts into his head, so it is none of its business what drug a
person puts into his body. In other words, just as we regard freedom
of speech and religion as fundamental rights, so should we regard
freedom of self-medication as a fundamental right. Instead of men-
daciously opposing or mindlessly promoting drugs, we should, para-
phrasing Voltaire, make this maxim our rule: "I disapprove of what
you take, but I will defend to the death your right to take it!"

To be sure, like most rights, the right of self-medication should
apply only to adults, and should carry with it unqualified responsibil-
ity for the effects which one's own drug intoxication behavior has on
others. Persons who commit criminal acts while under the influence
of drugs should not only be held responsible for their conduct, but,
in general, should be punished more severely than persons who com-
mit the same offenses while not under the influence of drugs.

The idea of free trade in narcotics frightens people, perhaps
because they believe that vast masses of the population would spend
their days and nights smoking opium or mainlining heroin, instead of
working and shouldering their responsibilities as citizens. But this is
a bugaboo that does not deserve to be taken seriously. Habits of
work and idleness are deep-seated cultural patterns; I doubt that free
trade in drugs would convert industrious people, such as the Americans,
the English, or the Germans, from hustlers into hippies at the stroke
of a legislative pen.

The other side of the coin regarding drugs and drug control is
actually far more important. Our present policies toward the problems
of drug abuse and drug addiction are actually inconsistent with our
most cherished moral sentiments concerning personal freedom and
responsibility; they gravely imperil our judicial and political institu-
tions and the liberties they guarantee; they aggravate rather than
ameliorate the so-called drug problem; and they are astronomically
expensive to boot. In short, I submit that our problem is exactly the
opposite of what it is generally claimed to be. The problem is not
drug abuse, but rather law abuse. What is wrong, what is immoral
and unconstitutional — what should be illegal — is not the taking of
drugs by some Americans, but the presumption by the American
government that it may tell us what drugs we can and cannot take,
thus, promoting, even compelling us to take those it approves, and
prohibiting and persecuting us for taking those it disapproves.

The prohibition of certain classes of drugs creates a brisk illegal
traffic in them, just as did the prohibition of alcohol a half-century ago.
Furthermore, our present national craze outstrips anything attempted
during Prohibition, for we now not only deliberately create an immense amount of criminal behavior among both the suppliers and the consumers of illicit drugs, but we also use tax monies to underwrite the so-called treatment of the non-existent illness called "drug addiction." The result is that we declare drugs "Our Public Enemy Number One," and wage a "War on Addiction," thereby generating a popular delusion suggestive of such earlier crowd madneses as the Crusades and the witch hunts.

The Constitution and the Bill of Rights are silent on the subject of drugs. Thus, when the American people decided to outlaw alcohol, they passed a constitutional amendment to do so. That clearly implies that, as American citizens, we have a constitutional right to medicate our bodies as we see fit. It is time that we look more closely, not only at the effects of harmful drugs, but also at the effects of harmful laws. In the history of mankind, many more people have been killed by laws than by drugs.

Let me add, informally, that I consider the persons who are engaged in what I would call the practice of "drug abusiology" as criminals against mankind such as were tried at Nuremberg.

Thank you.

MR. COHEN: I would add that constitutional lawyers who are trying to present some of the issues Dr. Szasz has raised, look to the ninth amendment which says that there are fundamental rights other than those specifically set forth in the rest of the Bill of Rights. That is the amendment that was used for the first time in decades, in the case of Griswold v. Connecticut\(^{25}\) which dealt with the dissemination of birth control information.

I, now, would like to call upon Dr. Brill.

DOCTOR HENRY BRILL: Although we all have been asked to discuss the political and philosophical issues connected with drugs, I would prefer to talk about practical experiences and facts which lead me to the conclusion that no one principle is sufficiently broad to cover this field. When one deals with problems that come in small packages — individuals and families that are in trouble — it is very difficult to offer either political or philosophical abstractions. People and their problems demand that something be done.

If I leave one clear statement on the record, I would like it to be that there is a cure, that there are recoveries. I have known many such cases as has everybody else who has had experience in the field.

\(^{25}\) 381 U.S. 479 (1965).
I take the time to say this because I heard somebody say here this morning that cures are rare. That is not true. Scientific studies have shown that even under the old system somewhere in the neighborhood of 40 per cent of the patients who went through Lexington and finally returned to New York City were clean twelve to fifteen years after their return. It is also true that 25 per cent were dead and that the rest were in and out of hospitals and followed a fluctuating course. To say that recovery is rare, even under the old system, is misleading.

Secondly, under methadone treatment, with which I have had close contact from its inception, a conservative estimate is that, among hard core cases, somewhere in the neighborhood of 60 to 70 per cent show a change of life style and a successful and satisfying adjustment.

We have heard statements about how little we know. They have to be interpreted carefully, however, because we know a great deal. The number of facts that have become available in the field of drug dependence in the last few years is incredible. Our lack of knowledge lies in our ability to interpret those facts and translate them into action.

The interpretation of the vast volume of information which is available is a frustration to those whose duty it is to formulate public policy. They are caught between the civil liberties issues, that have been so eloquently described here, and the demands of agonized families and the public; it is not an easy position in which to be. Many of you will be in that position someday, if the law does not change its nature. If you are lawyers, your attitude may depend on who your client is. If you are defending a patient, you may have one attitude. If you have a client with a family that is in distress because of the patient, you may have a different attitude.

The question whether addicts (I use the term in the old-fashioned sense, and I think it is a good term in spite of the fact that it has been abused) ever turn to treatment voluntarily has been raised. My view, and it can be documented, is that sometimes they do and that they do recover. They do not all have to be dragged in by the heels; however, the number that comes in voluntarily is relatively small. The vast majority and those who are the most serious social problems do not come willingly.

This raises other questions: (1) what is there about the behavior of the addict which makes it necessary to consider the use of coercion? and (2) is there a connection between addiction and crime? Anyone who has dealt with a number of addicts knows that there is a connection between addiction and crime; addicts are extensively involved in crime. Is there a connection between the detoxification process and
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a return to a better form of life? Of course there is. There is about a 95 per cent reduction in the amount of crime among successful methadone cases. That is hard to get around. Whether there is an effect on the overall crime statistics is a separate issue to which no answer has been given convincingly. That is what the Commission meant when it commented on the question.

We have several options open to us when we are faced with an individual who is involved in criminal behavior which is connected to or associated with his drug problem. He can be handled on a strictly legal level; I have seen that done with poor results. Thrown into the lockup, the addict goes into "cold turkey" withdrawal; he gets sick. If he is thrown in with prisoners who really do not belong in the same classification, the results can be brutal. It goes against the grain to consider and treat as criminals people who are, at least for a time, really sick in the true physical sense.

On the other hand, if one considers the addict as sick that raises all the issues that Dr. Szasz has raised: Is the state of dependence really an illness? That is a philosophical question that I will not attempt to answer.

Finally, there is a third option we might consider, and that is the so-called British system. I have been personally familiar with the British system since 1958 when I first visited that country. In my opinion, there is no analogy between the British problem and our own. I think it error to say that Britain and America started off on the same footing a hundred years ago. The British had neither a narcotic problem nor a street problem until about 1964-65.

The British heroin maintenance system provides the drug intravenously for the addict — entirely different from the American system. As long as intravenous opiate is available, oral methadone maintenance will be driven out by a species of Gresham’s law. The addict will not take oral methadone, which gives him no bang, or very little bang, when he can get the bang he wants from the intravenous drug.

The problem in England apparently has been contained since they started to issue heroin through government-controlled clinics. The number of addicts has not escalated as rapidly as it had been in the period 2 or 3 years before the new program started. On the other hand, the behavior of those who are being maintained has not improved nor has the morbidity, mortality, and the way in which they take their drugs.

For us to apply this system to 600,000 heroin users in the United States, which is one guesstimate, would be, in my opinion, impossible.
I have had experience with treating voluntary cases and with treating cases where the coercion was there but was not applied — that is, where sanctions were hanging over the addict’s head. There is no question that it is easier to treat a patient where sanctions exist in the background; when an addict feels that his treatment is purely voluntary, he may be unable to control himself. Whatever that means, it applies only to the abstinence program. With methadone, the treatment can be entirely voluntary. In fact, it is my opinion that it has to be entirely voluntary.

What society’s decision will be in the face of this kind of dilemma, I do not know. I can tell you that physicians in hospitals are not racing to take charge of the patients. They are reluctant to treat alcoholics, and they are even more reluctant to treat addicts, for a very good reason. They are difficult to treat and their treatment may have bad public relations repercussions. However, the problem is there and cannot be solved by rhetoric. I suspect that we will move from one point to the next, and that there will be some gradual development of a pragmatic technique.

There are pharmacological treatments in the wings right now which may make the opiate problem moot within ten years. That will not solve the other drug dependence problems, but it could be that a good pharmacological approach will make the difference and will save the Constitution.

Thank you.

MR. COHEN: Two points — one is that when you look at people who have been involved in a rehabilitation program or abstinence for a period of time, you can never know for certain whether the abstinence resulted from the rehabilitation program or whether the people matured or otherwise got clean themselves.

The second point is that earlier studies of continued criminality among addicts involved in methadone maintenance showed that these individuals, for the most part, were not committing crimes when they were in the methadone maintenance program. The addicts who were part of those programs, however, were hand selected. Later studies, indicate that the re-arrest rate among individuals on methadone maintenance is almost as high as when they were on the streets. This is a very unsettling statistic, because people looking at the addiction problem often assume that once addicts are brought into methadone maintenance programs they will not continue their criminal activity. Also, individuals stabilized in methadone maintenance programs are
probably less vulnerable to arrest. Therefore, I am a bit skeptical of statistics.

I have a few questions for panel discussion, but first I would like to address this to Dr. Brill. Assuming that addicts are going to commit crimes regardless of whether they are dependent on a drug, what real interest do we have in spending a billion dollars to lock people in jail or to force them into treatment? What are the dangers to society that result from addiction?

DR. BRILL: I think the general principle that addicts make more addicts has bothered communities. I was involved with a Black community in New York where we proposed a pilot program with heroin. Those highly experienced people told us bluntly: "Not in our neighborhood." The contagious quality of heroin use bothers every community where it has taken root.

MR. COHEN: Does anybody on the panel wish to respond?

PROFESSOR KITTRIE: My only answer to that would be that Christians beget Christians and Blacks beget Blacks, but this leads us to the fundamental question of whether people who take drugs are dangerous per se or whether they are dangerous primarily when perpetrating the crimes that secure funds for more drugs. The statistics seem to indicate that the major crimes committed by drug addicts are crimes to get drugs. Obviously, if they are put on methadone, they get their drugs at a government office and do not have to commit crimes to support their habit. I do not see why the principle is not applicable to maintenance with heroin.

DR. BRILL: It would take a while to explain the difference between methadone maintenance and the state of heroin addiction. You have to accept my word that there is a world of difference. But there is one important fact that you must realize. A state of chronic inebriation — and I mean inebriation in the usual sense — is undesirable. A basic objection to the taking of heroin intravenously, four or five times a day, is that the people associated with the addict — his family — object to having him in a state of chronic inebriation — chronically disabled. So, there is a human side to this thing. It goes beyond the crimes they commit.

MR. COHEN: If the position of some panel members is to do away with the control of drugs and drug users, are we talking about giving an addict an absolute right to obtain an uninterrupted supply of drugs? In other words, does any law enforcement effort to keep
drugs from coming into the country cut down on the addict’s right to use drugs in the same way the rest of us breath the air?

If we are not talking about a completely free market system, we are talking about a maintenance system. Do we realize that individuals maintained by physicians at some point are going to want to use more drugs than the physicians are going to allow? Physicians in England start to cut back on the dosage levels once they feel they are being successful in the rehabilitation process. This has resulted in a black market problem in that country. You can have a certain number of addicts maintained on drugs, but some will go to the black market for additional supplies. Therefore, do we not really have to realize that there are going to be social costs, in terms of increasing addiction, with either an interrupted supply of drugs or maintenance programs?

DR. SZASZ: I want to say something very briefly. It is difficult to listen to the kind of thing I am going to say. It is far easier to read about it, but I hope you will bear with me.

I want to dwell just a little on semantics. While I agree with everything that you said, Mr. Cohen, I really cannot respond to it properly without pointing out that, as I view the phenomenon in the situation that I am describing or suggesting, there would be no addicts because there are no addicts until somebody calls them that and has the power of the law to impute that status to them.

There are people with black skins. There are no “niggers” floating around in the world. There are people who have the Jewish faith. There are no “Christ-killers.” There are people who take chemical agents. There are no “addicts.” Until we learn that, we will just produce confusion. The chemical agent you may want to take may not be liked by the government. If that is the case, the government calls it a narcotic. If the government likes it, it calls it a food. It is that simple.

If you are a Catholic or a Protestant, then you have the true faith. If you are a Mohammedan or a Jew, you are a heretic, or vice versa. Methadone maintenance is a medical religion and the theology in it is the medical profession. To my mind, however, maintenance is the disease. Methadone maintenance, to me, is the gas chamber to which the Blacks go as willingly as the Jews went in Germany. The coincidence is not a coincidence.

MR. MOSS: You remind me of the fellow who said, “If I am going to be shot, I would rather be shot with a big gun than a little one.”

DR. BRILL: Let me respond about methadone maintenance because it has become a fighting subject in the past few months. The large proportion of all methadone cases are White, not Black. The original
attitude in the Black community was one of suspicion, as Dr. Szasz
has mentioned. However, it has now been accepted in one Black com-
community after another. It is recognized for what it is, a better way of
living than that which it replaces.

If anyone has any doubts as to what the results of a free opiate
market are, he should read the history of China, when opiates in their
mildest form were on a free market. There were tens of millions of
opium addicts and it took a revolution to solve the problem.

MR. MOSS: Something Dr. Brill said leads me to pose a ques-
tion. In our jurisdiction, 30 per cent of the people are Black and we
simply do not have any drug problem within that group that is worth
mentioning. We do have a drug problem with the Chicanoes, but not
with the Blacks. Is there any relationship in the North between Blacks
and drugs?

MR. COHEN: I think the incidence of addiction here is con-
siderably higher among the people in the ghetto.

PROFESSOR KITTRIE: If I may just add something — it is
very easy to look for so-called progressive labels and become caught in
a bind. I understand what Dr. Brill means when he speaks of a malfunc-
tioning member of the family, but what are you going to do about it? I
would suggest that the fact that the individual is taking certain drugs
may be merely incidental.

I have found over a number of years of research that we are always
looking for easy explanations for social problems. About 10 years ago
I was trying to find out what accounts for criminality. One of the ex-
planations with which I was furnished was that 60 or 70 per cent of
all people who were in prison were there because they had committed a
crime while intoxicated. Today, we are told that 60 or 70 per cent of
those in prison are there because they had been taking drugs. Obviously,
they are there because they were committing certain crimes, and while
there may be many explanations, to attempt to attribute criminality to a
group labeled that way may be very misleading.

While Dr. Brill tells us that we must respond to malfunctioning
people with compassion, I want to tell you that there were probably
30,000 to 50,000 people dismissed from the Armed Forces simply be-
cause they were taking certain drugs. I find the lifelong stigma attached
to these people in the name of compassion very, very unsatisfactory.

There is also a strong movement these days to say that we really
do not want to use criminal sanctions against people who take drugs
because they are brutal. The alternative being espoused is mandatory
medical treatment. The question is whether there really is any difference between the two views.

Further, we really ought to ask whether there is such a thing as rehabilitation. I suggest that not only is there no such thing as medical treatment in this field, but that there is also probably no such thing as rehabilitation in the criminal field. You can detoxify somebody, you can dry him out, but what is waiting for him when he gets back to society? Is there going to be a job for him? Is there going to be a place for him to live? Those are the key questions, and treatment is not the magic solution.

MR. COHEN: Everyone on the panel, except Dr. Brill, is opposed to mandatory minimal sentences, yet, in the real world, it looks as if mandatory minimals will be enacted in New York. Whether plea bargaining, parole, and probation for the drug offender will also be eliminated is still an open question. I think the members on the panel, again with the exception of Dr. Brill, are also against any prison terms for drug users.

Let us go over some of the other areas of concern. Urinalysis to protect drug usage in schools? I assume everybody is against that. Pre-trial preventive detention — uniformly, everybody objects to it. Involuntary commitment of any sort also meets with opposition. Pre-trial diversion has not been discussed yet, but it is an option that many are now looking to with greater favor.

The whole debate has been shifted. For a while people thought they really could talk about decriminalization. Now people say the best thing we can do is take people who have been arrested for various crimes — not only drug crimes — and refer them to treatment instead of prosecuting them. That may be the humane option which is available within our political context.

MR. MOSS: You pose an interesting question. I agree with what you said about treatment, but I am not going to do it; you are not going to do it; the policeman is not going to do it; the doctor is not going to do it; the mother and father are not going to do it. Who is? If you can answer that, tell me where it is going to be done and who is going to pay for it. I am not. Are you?

MR. COHEN: Right now a billion dollars of the taxpayers' money has gone into setting up treatment facilities for addicts all over the country. The goal of this Administration is to get every addict into treatment. You heard Dr. Jaffe say that every addict who wants treatment is going to get it.
MR. MOSS: We have addicts in my jurisdiction, but they are handled by churches and other voluntary organizations. We do not send them there, they go themselves.

MR. COHEN: When you look at the population of treatment facilities, you find that a high percentage of the patients are there because a judge or policeman told them to help themselves or go to jail. They may have been on probation after having been convicted of a minor crime and may have been told that if they did not stay in the treatment program their probation would be revoked.

So, ostensibly, we have the same situation as I mentioned existed in the Soviet Union where only 3 per cent of the people are involuntarily committed. Ninety-seven per cent are there voluntarily, but if they do not stay put, within five seconds the hammer comes down and they are in involuntarily. That is the reason why the Marihuana Commission will propose a uniform bill providing for involuntary commitment petitions. The argument is that they will never be used, that they are just there in case somebody steps out of line.

The number of people really in treatment voluntarily is an open question.

DR. BRILL: You voted for me on the mandatory minimals, but I had better speak for myself. The Commission report does not come down in favor of mandatory minimals. I was only trying to present the case for treatment — the fact that it, pre-trial diversion, and perhaps other methods will be necessary. I do not think we can brush the whole thing aside by redefining its as a non-problem; it is a real problem.

MR. COHEN: Assuming, however, that we are going to decriminalize drug possession, do the members of the panel believe that referral into treatment is a better alternative than to take addicts who commit crimes and to put them in jail?

PROFESSOR KITTRIE: I cannot accept your phrasing of the question. You are basically eliminating a very significant part of the problem if nobody will be charged with possession or use of narcotics.

I would appreciate it if, sometime during the discussion, Dr. Brill, who served on the Commission and was very prominent on it, would tell us why the Commission could not take the route of saying possession and use would be decriminalized. If, indeed, possession and use are not criminal offenses, and if that undercuts the illegal market in drugs, then we will only be faced with people who commit...
crimes and are, incidentally, addicts. From my point of view of social defense, those people should be put in prison. My experience in the District of Columbia has been that if a person needs a psychiatrist he can get one more easily at Lorton, which is a correctional institution, than at St. Elizabeth's, which is a mental institution.

MR. COHEN: I think what I am trying to say is that the possibility of decriminalizing drug possession is about as likely as waking up tomorrow morning and finding the internal combustion engine banned. It just is not going to happen. We cannot look at decriminalization as a realistic possibility. But, assuming, hypothetically, that we are going to have decriminalization, do we prefer to see drug users who commit crimes locked up in jail or do we prefer to see them referred to a treatment program?

MR. MOSS: We no longer imprison people for addiction. That has been prohibited by the United States Supreme Court, and I agree.

MR. COHEN: People are not locked up for addiction, but for drug possession, a symptom of addiction, which is still a crime. We take a symptom of the disease and use that as a vehicle for locking up addicts.

MR. MOSS: This gets back to the age-old question regarding the extent to which one man should impress his views upon other men. I think if I had the power, I would go after drugs at their source, that is, where they are grown. My secondary line of attack would be directed to places of importation.

We only arrest addicts in Texas, and I presume it is the same everywhere, when they commit crimes other than addiction. If we find that an arrested person is an addict, we have no choice but to prosecute him as if he were not an addict. Once he is in custody, it becomes a problem for the medical authorities of the institution in which he is confined.

At one point we had a good program; an addict could voluntarily go to a federal institution like the ones in Fort Worth or Lexington, and stay there X months or days, or for whatever period the local medical authorities thought was best for him. He would not be tried unless he refused to go. The program worked for a while, but, regretfully, it was terminated as a result of a Supreme Court decision. It seems to me that making possession rather than addiction the crime is only playing with legal semantics since, obviously, addicts have drugs in their possession.

27. Id.
PROFESSOR KITTRIE: I think your question, Mr. Cohen, is important. You are really asking whether, if there is going to be no major change in the law, we should encourage diversion programs. I assume what you mean by diversion is the option for one charged with a criminal offense to choose between treatment and prison.

If you can show that this is the only option we have and if you can prevent somebody from being criminally labeled by offering him another option, I would probably choose it. You have to make sure, however, that the option does not really impose greater restrictions on the individual than if he were sentenced and sent to prison.

MR. COHEN: I made the point before that only 15 to 20 per cent of those convicted of crimes can be sent to prison because we do not have sufficient prison space. The people who get diverted into treatment are those who would otherwise be out on probation — so we are really looking at compulsory treatment versus probation, not compulsory treatment versus incarceration.

DR. SZASZ: I cannot really answer the question the way it is framed because I believe there is no such a thing as involuntary treatment; it is a contradiction of terms.

The favorite indoor sport of mankind is to persecute other people. The only question is deciding who to persecute. We have run out of Blacks, women, and Jews, so we now persecute patients. We rotate the titles. A few years ago it was homosexuals and schizophrenics, but fashions change and now they are addicts. Five years from now it will be someone else.

We talk about involuntary treatment as though we were dealing with a disease, but the two most rampant, objective, identifiable, and contagious diseases in America today have no legal compulsion behind them for treatment. You can have all the syphilis you want in New York City and nobody can make you a victim because of it, but syphilis is a more objective and identifiable disease than addiction. I submit that talking about involuntary treatment for addiction is on a par with another commission coming out with a new treatment for addiction to coffee. If they decide that there is a coffee addiction problem because the government does not like coffee, there will be a program of maintenance on tea. It is nonsensical.

Maintenance on methadone for heroin is like maintenance on scotch for addiction to bourbon. Although it is also ideological and political, it is essentially a business matter. Take it away from the private Mafia and give it to the Government Mafia, the Special Action
Office. It is a struggle for monopoly just as was the Opium War. Now we have methadone wars — conversion from heroin to methadone.

MR. COHEN: One of the things happening now under the guise of trying to get people into treatment is that people arrested for crimes, are given a urinalysis to determine whether they are using drugs. This will not demonstrate whether a given person is an addict, but if he is the judge will have an indication that he has used certain drugs. No lawyer is present at that time, and there is nothing to keep the judge from deciding that, because the individual is a drug user, he is going to keep him locked up by setting high bail.

The other alternative is to release the arrestee to a treatment program where he will be addicted to methadone. He may have tried drugs only two or three times, but the treatment program people can decide that, because he has had drugs in his urine, he has to be in the program and has to be addicted to methadone. They can require him to undergo continuing analysis, and, then, at the time of trial — the way I see the proposals developing over the next two or three months — there will be no right for him either to escape prosecution or escape incarceration. So, there is a possibility that a person could be maintained on methadone up until the time of trial and then be sent to a state prison where he will be forced to undergo withdrawal.

That is the picture as it may evolve, and it is not farfetched. I think it is less far-fetched than to believe that there will be any real public debate about drug decriminalization.

DR. BRILL: Anybody who knows the technical side of methadone maintenance knows that it just cannot happen that way. An individual has to have a true history of heroin dependence, not merely a single specimen in the urine before he will be placed in a maintenance program. Of course, there are physical indications — fresh needle marks and tracks — which also help determine whether an individual is really dependent on heroin.

I see no problem if an individual is transferred to methadone and then is convicted — withdrawal from methadone is the standard way to withdraw anybody from heroin. People talk about the horrors of withdrawal from methadone without realizing that it is the standard medical procedure for withdrawal from heroin in the Western World today.

MR. COHEN: I think there is controversy as to whether withdrawal from methadone is more traumatic than withdrawal from heroin. It takes a longer period of time.
DR. BRILL: For the past 15 years the standard method for withdrawal from heroin has been the use of methadone — long before it was used for maintenance.

C. General Discussion

MR. COHEN: We will now open the panel discussion for questions.

PARTICIPANT: I would like to address this to the entire panel. I have been hearing a lot of half-truths. I supervise narcotic agents and my experience has shown that those on methadone do not regress to criminal activity. We have a recidivism rate in California of under 5 per cent.

The effects of withdrawing from methadone are by far greater than from heroin. In California, we have not had one death from heroin withdrawal in the last 10 years, whereas we have had many from methadone.

Some of you gentlemen might benefit from going out on the street and talking to the addicts rather than sitting and reading your statistics, because your statistics are wrong. Believe it or not, the average narcotics addict would like to lead a straight life; he would like to be able to buy a six pack of beer, go to the drive-in, get up at eight and work until five o'clock in the afternoon. He does not want to stay in the cyclical pattern of heroin addiction, yet the federal government has deemed it sufficient to allocate 150 slots for methadone maintenance programs to Los Angeles County when we have a waiting list of 3,400. Even though methadone is not the answer to the heroin problem, it is a step in the right direction.

PARTICIPANT: I was disturbed by Dr. Szasz’s comment equating methadone maintenance with medical persecution because at the present time there are no alternatives. We can talk about decriminalization, but it is not going to happen. The climate in the United States right now is not one which will permit the decriminalization of pot, much less heroin. Therefore, we are faced with the necessity for treatment. I find it disturbing to equate treatment, therefore, with a form of genocide.

DR. SZASZ: Of course, it is the same as the difference between winning a war and losing it. If the Germans had won they would have continued to call what they were doing treatment, which is what they called it all along; but they lost and, therefore, we called it genocide.
Nobody walks into a methadone maintenance clinic. The very language is misleading. If there were a free market in drugs — methadone, heroin, opium, methaqualone, and all the others, none of which I like or promote — people could walk into a clinic as they now walk into a Ford dealership rather than a Chevrolet dealership. What we now have is people walking in under compulsion, and the entire semantics of protection has to be corrected. What we call treatment in America is 99 per cent coercion. I consider all involuntary mental treatment harmful.

PARTICIPANT: The gentleman from Los Angeles did not talk about a coercive waiting list; he spoke of a waiting list free for people to sign up. They want to get in and get off the heroin cycle.

DR. SZASZ: We are both talking English and even though I have an accent, I think I am speaking more accurately because they would not be on that list if they could go out and legally buy heroin.

PARTICIPANT: But that is not a reality of life.

DR. SZASZ: It was not a reality of life to be Jewish in Germany, either. America was a very good country before 1914 — people from all over the world were trying to come here. You could buy all the opium freely at a drugstore. Opium has been around for 5,000 years. It is the oldest drug known to mankind. Yet, we are now saying nobody can live with it.

Herman Goering was a chronic morphine addict. He was perfectly healthy and piloted airplanes. (I can document it.) He never took methadone, although I do not even know if methadone had been invented then. He had a choice among drugs, took morphine and stayed perfectly well.

PARTICIPANT: I am Dr. Joseph Benforado, a physician and pharmacologist. I have the privilege of treating people who have problems with narcotic addiction, but I do not know very much about the ways in which a society controls the behavior of its people.

I agree with Dr. Brill that addicts make more addicts. I also feel very strongly that we would not need any laws in the utopian society that Dr. Szasz is talking about. However, we need laws in our society of today. I would like to ask Dr. Szasz to express his views about societal controls over the behavior of its free citizens. For example, if a gentleman enjoys walking down Main Street dismembering a live dog because that is his bag, and he is not harming anyone else, should society make laws concerning his behavior?
MR. MOSS: Do you resolve that down to a question of to what extent should I be able to do what I please with my own body?

DR. BENFORADO: Exactly.

MR. MOSS: If the doctor will permit me, let me interject that about a year ago I had the ignominious task of trying to uphold the constitutionality of a Texas law making it compulsory to wear a helmet while riding a motorcycle. I thought it was one of the most inane laws ever written and, unfortunately, I won the case — it was held constitutional. The argument was: What difference does it make? If the rider wants to bust his own skull, it is all right; there is no way he can hurt anybody else. The reply was that there will be wrecks. Yet, there will be wrecks even with the helmet, and there is some evidence that there will be more because cyclists cannot hear as well while wearing helmets.

So I, too, would like an answer to the question of society's right to limit behavior, because I have fought with it in the courts.

DR. SZASZ: I have given a great deal of thought to such questions, but I am not sure how much justice I can do to the complexity of the issue. It is obvious that there can be no such thing as society without some consensus of what is permissible behavior. Certainly, the idea of someone going around dismembering a dog does not appeal to me.

I have no difficulty with the controlling of this kind of behavior through the traditional criminal sanctions. I think everybody, except out and out anarchists, would agree. However, criminal sanctions are not synonomous with brutality; a $10 fine can be sufficient. The same rationale applies to going through a red light. How many of you would like to be ordered to undergo psychiatric examination or treatment instead of being given a ticket? That, however, is in no way analogous to taking drugs. An extremely difficult pharmacological technology is often needed to determine whether somebody is taking a drug. If one is clever, you will have a difficult time guessing he is on drugs. Freud was a cocaine addict for 3½ years. Halsted, the founder of Johns Hopkins Medical School, was a lifetime morphine addict. About 15 per cent of all the doctors in the Wehrmacht were on morphine for the 15 years between World War I and the time Hitler remedied the situation.

You always hear about the models. This morning you heard about the legal model, the medical model, and the sociological model.

They are all wrong. Somebody else teaches a model — religion — and I mean it literally. This is a religion. When you offend someone in practicing your religion — your religion is to kill someone — that is one thing. But if your religion is a private matter so that you have to be ferreted out like secret Jews in Spain, that is a completely different thing.

My model is clearly a religion as I indicated in the Voltaire quotation. Voltaire made that statement: “I disagree with what you say but I do defend your right to say it,” when standing between the two extremes of his time — the Inquisition which was dying down and the new anticlericalism which was ready to kill the priests. He was saying: If you want to believe whatever it is that you believe as a good Catholic, fine; I do not believe it, but you should believe it. Similarly, if you want to drink coffee, fine; if you want to take opium, all right; just leave me alone. This is essentially the ethic of individual freedom and the high respect for the common good — much higher than we now have.

MR. COHEN: Psychiatrists who disseminate heroin to addicts in England have come to the Drug Abuse Council and, uniformly, were vehemently against exporting their system to the United States where there are maybe 200,000 addicts. They felt that in light of the inability of people on maintenance to function in their communities, to get along with their families, or to lead fulfilling lives, the English program would be catastrophic in the United States. This was a surprise to us because we had expected that people involved in the program of maintaining addicts would come over here and proselytize, or at least argue in favor of it.

PROFESSOR KITTRIE: If I may just add to this — you are raising the question of the amount of control one may exercise over his body. I think in the final analysis I would probably opt for an individual having control over his body rather than for having the state step in, but I am not really sure you cast the question in the proper light because of the people about whom you are talking. Part of the problem with the people you are describing is that they do not have jobs and are underprivileged.

You assume that drugs cause irreparable damage to the body, but it is not clear what damage is caused by marihuana or heroin if used by people who have the proper means, diet, and jobs.

There is evidence that some doctors taking drugs under controlled conditions — eating well and sleeping properly — are dying, but so what? They are taking a certain risk, not much worse than the risk taken when sky diving. The main thing about the people you
are describing, and the reason you are concerned about them, is that they do not have a place to sleep nor do they have a proper diet. That is the big problem.

MR. COHEN: You know, Mr. Sonnenreich was talking, this morning, about a theoretically acceptable level of drug addiction in society. Assume 8 to 10 million is the acceptable number. If all those people are ones without jobs, education, or the proper diet — people in the Black community — are we willing to tolerate the addiction if it is only symptomatic, and not the cause of their state? Even if addiction exacerbates the problem, are we willing to go along with a system which enables this number of people to get involved in drugs?

I think, as Professor Kittrie pointed out, the number of people who are opposed to drug dissemination and who are in favor of mandatory minimal is higher in the Black community than it is among good, right-thinking liberals who have only studied the problem and had intellectual discussions about it.

PARTICIPANT: I have a question for Dr. Brill. I am a community lawyer and one day someone called me because a mentally ill woman was being evicted. The caller asked me to help get the woman into a mental institution because she was a schizophrenic and might harm herself. My first instinct was to play God and help the woman, but then I thought about it and finally decided that she had as much right to be on the street and to be a schizophrenic as I did. That was her choice; it was not up to me to commit her to a mental institution. It seems that Dr. Brill has taken the opposite position, thinking that he was helping this woman maintain herself and lead a more useful life.

Doctor, you talk about the standard ways of doing things and about statistics. I would like to know where you get your standards and how you define a proper way of life. It is disturbing to have a few people in a centralized place dictating how people should live and what a particular policy should be on detoxification or on any other treatment.

DR. BRILL: Very briefly, it is the judge, not the psychiatrist, who certifies a patient to a hospital or other treatment facility. Your point, then, is one you should take up with the judiciary.

I do not think we should get into the field of schizophrenia, but, since you asked, I must say that schizophrenia is a treatable condition.

MR. COHEN: I would like to know how many times a judge decides against certification for commitment after a psychiatrist testifies that an individual is dangerous and a schizophrenic.
DR. BRILL: Very frequently. Don't groan. This is my business and I have the information. Your information, if I am not mistaken, is relatively old. At present, I stand by what I say: Very frequently.

PARTICIPANT: I was a mental health and retardation worker in a local county and left that job about five months ago. I never saw a case in which a judge did not accept and follow the psychiatrist's testimony.

MR. MOSS: Come to Texas.

SAME PARTICIPANT: After listening to you, I have concluded you are a little smarter down there.

I am glad Dr. Szasz said what he did. The other discussion concerning available treatment options merely said to me: "Given the fact that we have to execute people, do we cut off their heads or do we put them in the electric chair." No one except Dr. Szasz asked whether we should play the game at all.

Another point that has been bothering me is that all the available money gets funneled into drug and alcohol programs. It is not spent to deal with many of the other social and economic problems that have plagued society for a long time and which, in themselves, have an effect on the use of drugs and alcohol.

PARTICIPANT: I would like to bring up a point concerning the involuntary or voluntary commitment of drug addicts to mental institutions or to hospitals for detoxification as opposed to commitment to specialized treatment centers. It appears to me that what that does is make the hospital or the institution, and the doctor in charge of the patient, an alternative to prison and, thereby, makes the criminalization easier for the medical profession to accept.

MR. MOSS: Exactly. You said it better than I did.

MR. COHEN: The point was that when you take people from the criminal justice system and put them in treatment, you put the doctors in the same position as the guards and you look at the institutions in which treatment is taking place in the same way you look at a jail.

PARTICIPANT: I think this whole panel is confused about what drug addiction is. I do not know how Dr. Szasz, a medical doctor, as well as a psychiatrist, can say that addiction is not a medical disease and that heroin or barbiturate withdrawal cannot cause physi-