Death by accidental overdose is an altogether different matter. But can anyone doubt that this danger now looms so large precisely because the sale of narcotics and many other drugs is illegal? Those who buy illicit drugs cannot be sure what drug they are getting or how much of it. Free trade in drugs, with governmental action limited to safeguarding the purity of the product and the veracity of the labeling, would reduce the risk of accidental overdose with "dangerous drugs" to the same levels that prevail, and that we find acceptable, with respect to other chemical agents and physical artifacts that abound in our complex technological society.

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

WITHDRAWAL PAINS FROM TRADITION

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

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

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

The concept of free trade in drugs runs counter to our cherished notion that everyone must work and idleness is acceptable only under special conditions. In general, the obligation to work is greatest for healthy, adult, white men. We tolerate

idleness on the part of children, women, Negroes, the aged, and the sick, and even accept the responsibility to support them. But the new wave of drug abuse affects mainly young adults, often white males, who are, in principle at least, capable of working and supporting themselves. But they refuse: they "drop out"; and in doing so, they challenge the most basic values of our society.

The fear that free trade in narcotics would result in vast masses of our population spending their days and nights smoking opium or mainlining heroin, rather than working and taking care of their responsibilities, is a bugaboo that does not deserve to be taken seriously. Habits of work and idleness are deep-seated cultural patterns. Free trade in abortions has not made an industrious people like the Japanese give up work for fornication. Nor would free trade in drugs convert such a people from hustlers to hippies. Indeed, I think the opposite might be the case: it is questionable whether, or for how long, a responsible people can tolerate being treated as totally irresponsible with respect to drugs and drug-taking. In other words, how long can we live with the inconsistency of being expected to be responsible for operating cars and computers, but not for operating our own bodies?

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

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

Let us see how far some of the monies spent on the war on addiction could go in supporting people who prefer to drop out of society and drug themselves. Their "habit" itself would cost next to nothing; free trade would bring the price of narcotics down to a negligible amount. . . .

. . . free trade in narcotics would be more economical for those of us who work, even if we had to support legions of addicts, than is our present program of trying to "cure" them. Moreover, I have not even made use, in my economic estimates, of the incalculable sums we would save by reducing crimes now engendered by the illegal traffic in drugs.

THE RIGHT OF SELF-MEDICATION

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

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

John Stuart Mill said (approximately) that a person's right to swing his arm ends where his neighbor's

nose begins. And Oliver Wendell Holmes said that no one has a right to shout "Fire!" in a crowded theater. Similarly, the limiting condition with respect to self-medication should be the inflicting of actual (as against symbolic) harm on others.

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

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

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

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

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

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

Our attitude toward sexual activity provides another model for our attitude toward drugs. Although we generally discourage children below a certain age from engaging in sexual activities with others, we do not prohibit such activities by law. What we do prohibit by law is the sexual seduction of children by adults. The "pharmacological seduction" of children by adults should be similarly punishable. In other words, adults who give or sell drugs to children should be

regarded as offenders. Such a specific and limited prohibition—as against the kinds of generalized prohibitions that we had under the Volstead Act or have now with respect to countless drugs—would be relatively easy to enforce. Moreover, it would probably be rarely violated, for there would be little psychological interest and no economic profit in doing so.

THE TRUE FAITH: SCIENTIFIC MEDICINE

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

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

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

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

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

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

I propose a medical reformation analogous to the Protestant Reformation: specifically, a "protest" against the systematic mystification of man's

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

LIFE, LIBERTY, AND THE PURSUIT OF DRUGS

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

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

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

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

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

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

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

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

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

Discussion Questions

1. What, according to Szasz, are some of the myths surrounding the notion of drug addiction? Discuss how Elvine Jellinek (see page 279) might respond to Szasz. Which person presents the stronger argument? Support your answers.
2. Is Szasz being logically consistent in his rejection of legal access to drugs and alcohol for teenagers? If it is wrong for children to use certain "dangerous" drugs, why isn't it also wrong for adults to use the same drugs? Support your answers.
3. Discuss whether Szasz commits the fallacy of appeal to tradition when he argues that we have a constitutional right to use drugs. Or can his argument for a "right of self-medication" stand without appeal to the Constitution? Support your answer.
4. Moonshining—the illegal production and sale of distilled spirits—is an underground art in some rural parts of the Atlantic provinces in Canada. The Royal Canadian Mounted Police have received a growing number of tips and complaints about the whereabouts of illegal stills. Discuss whether laws that prohibit moonshining violate the right of citizens to exercise control over their own lives. Discuss also how Szasz would respond to prohibition.

JAMES Q. WILSON

Against the Legalization of Drugs

James Q. Wilson was a professor of political science at Boston University and former chair of the National Advisory Council for Drug Abuse Prevention. He was also the author of *The Moral Sense* and *Crime and Human Nature*. In this article Wilson rejects the libertarian view that citizens have the right to use drugs and to drink anything they want. Instead, Wilson argues that the harms of legalizing drugs outweigh the harms of prohibition.

"Against the Legalization of Drugs," *Commentary* 89, no. 2 (February 1990): 21–28.

Critical Reading Questions

1. What arguments does Wilson use to show that drug prohibition is morally justified?
2. What is Wilson's view on the disease model of addiction?
3. What evidence does Wilson use to support his position that legalizing drugs would increase their use?
4. Which drugs does Wilson think should be prohibited and why?
5. Why does Wilson reject the concept of drug abuse as a "victimless crime"?
6. Why is Wilson appalled by the argument that drug abusers should be allowed to kill themselves?
7. How does Wilson respond to the antiprohibition argument that the illegality of drugs increases crime?
8. According to Wilson, what are some of the benefits of making drugs illegal?
9. According to Wilson, why would drug treatment be less successful if drugs were legal?
10. What is Wilson's view on the morality of tobacco use? What are the similarities and differences, according to Wilson, of tobacco use and cocaine use?
11. What is Wilson's view on the morality of alcohol use?
12. Why does Wilson dislike the "war on drugs" metaphor? What metaphor does he prefer?
13. According to Wilson, what is the role of science in helping us understand and cope with addiction?

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

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

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

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

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

RELIVING THE PAST

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

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

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

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

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

But the shift to clinics did not curtail the growth in heroin use. Throughout the 1960s the number of addicts increased—the late John Kaplan of Stanford estimated by fivefold—in part as a result of the diversion of heroin from clinic patients to new users on the streets. An addict would bargain with the clinic doctor over how big a dose he would receive. The patient wanted as much as he could get, the doctor wanted to give as little as was needed. The patient had an advantage in this conflict because the doctor could not be certain how much was really needed.

Many patients would use some of their "maintenance" dose and sell the remaining part to friends, thereby recruiting new addicts. As the clinics learned of this, they began to shift their treatment away from heroin and toward methadone, an addictive drug that, when taken orally, does not produce a "high" but will block the withdrawal pains associated with heroin abstinence.

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

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

BACK TO THE FUTURE

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

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

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

* I do not take up the question of marijuana. For a variety of reasons—its widespread use and its lesser tendency to addict—it presents a different problem from cocaine or heroin.

Women are much more likely to use crack than heroin, and if they are pregnant, the effects on their babies are tragic. . . . Cocaine harms the fetus and can lead to physical deformities or neurological damage. Some crack babies have for all practical purposes suffered a disabling stroke while still in the womb. The long-term consequences of this brain damage are lowered cognitive ability and the onset of mood disorders. Besharov estimates that about 30,000 to 50,000 such babies are born every year, about 7,000 in New York City alone. There may be ways to treat such infants, but from everything we now know treatment will be long, difficult, and expensive. Worse, the mothers who are most likely to produce crack babies are precisely the ones who, because of poverty or temperament, are least able and willing to obtain such treatment. In fact, anecdotal evidence suggests that crack mothers are likely to abuse their infants.

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

HAVE WE LOST?

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

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

Have we lost today? Not at all. High-rate cocaine use is not commonplace. The National Institute of Drug Abuse (NIDA) reports that less than 5 percent of high-school seniors used cocaine within the last thirty days. . . . Medical examiners reported in 1987 that about 1,500 died from cocaine use; hospital emergency rooms reported about 30,000 admissions related to cocaine abuse. . . .

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

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

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

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

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

THE BENEFITS OF ILLEGALITY

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

First, treatment. All the talk about providing "treatment on demand" implies that there is a demand for treatment. That is not quite right. There are some drug-dependent people who genuinely want treatment and will remain in it if offered; they should receive it. But there are far more who want only short-term help after a bad crash; once stabilized and bathed, they are back on the street again, hustling. And even many of the addicts who enroll in a program honestly wanting help drop out after a short while when they discover that help takes time and commitment. Drug-dependent people have very short time horizons and a weak capacity for commitment. These two groups—those looking for a quick fix and those unable to stick with a long-term fix—are not easily helped. Even if we increase the number of treatment slots—as we should—we would have to do something to make treatment more effective.

One thing that can often make it more effective is compulsion. Douglas Anglin of UCLA, in common with many other researchers, has found that the longer one stays in a treatment program, the better the chances of a reduction in drug dependency. But he, again like most other researchers, has found that drop-out rates are high. He has

also found, however, that patients who enter treatment under legal compulsion stay in the program longer than those not subject to such pressure. . . . If for many addicts compulsion is a useful component of treatment, it is not clear how compulsion could be achieved in a society in which purchasing, possessing, and using the drug were legal. It could be managed, I suppose, but I would not want to have to answer the challenge from the American Civil Liberties Union that it is wrong to compel a person to undergo treatment for consuming a legal commodity.

Next, education. We are now investing substantially in drug-education programs in the schools. Though we do not yet know for certain what will work, there are some promising leads. But I wonder how credible such programs would be if they were aimed at dissuading children from doing something perfectly legal. We could, of course, treat drug education like smoking education: inhaling crack and inhaling tobacco are both legal, but you should not do it because it is bad for you. . . .

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

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

THE ALCOHOL PROBLEM

. . . Alcohol, like heroin, cocaine, PCP, and marijuana, is a drug—that is, a mood-altering substance—and consumed to excess it certainly has harmful consequences: auto accidents, barroom fights, bedroom shootings. It is also, for some people, addictive. We cannot confidently compare the addictive powers of these drugs, but the best evidence suggests that crack and heroin are much more addictive than alcohol.

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

And let there be no doubt about it—widespread heroin and cocaine use are associated with all manner of ills. Thomas Bewley found that the mortality rate of British heroin addicts in 1968 was 28 times as high as the death rate of the same age group of non-addicts, even though in England at the time an addict could obtain free or low-cost heroin and clean needles from British clinics. Perform the following mental experiment: suppose we legalize heroin and cocaine in this country. In what proportion of auto fatalities would the state

police report that the driver was nodding off on heroin or recklessly driving on a coke high? In what proportion of spouse-assault and child-abuse cases would the local police report that crack was involved? In what proportion of industrial accidents would safety investigators report that the forklift or drill-press operator was in a drug-induced stupor or frenzy? We do not know exactly what the proportion would be, but anyone who asserts that it would not be much higher than it is now would have to believe that these drugs have little appeal except when they are illegal. And that is nonsense.

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

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

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

SCIENCE AND ADDICTION

One advantage of containing a problem while it is still containable is that it buys time for science to learn more about it and perhaps to discover a cure. Almost unnoticed in the current debate over legalizing drugs is that basic science has made rapid strides in identifying the underlying neurological processes involved in some forms of addiction. Stimulants such as cocaine and amphetamines alter the way certain brain cells communicate with one another. . . .

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

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

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

Discussion Questions

1. Wilson claims that tobacco, unlike cocaine, corrodes our natural sentiments of sympathy and duty. Do you agree? Should tobacco be made illegal across the board for people of all ages? Or is there a relevant moral distinction between cocaine and tobacco as Szasz claims? Support your answers.
2. Compare and contrast Wilson's position on the legalization of drugs, for minors and for adults, with that of Thomas Szasz.
3. Discuss how Wilson would most likely react to the Canadian Marijuana Medical Access Regulations (2001) legalizing the use of marijuana for medical purposes.[39]
4. Preemployment drug screening and employee drug testing have become commonplace since the 1980s. Many Fortune 500 companies, for example, now have drug-testing programs. Some colleges are also considering mandatory drug-screening programs for undergraduates. Discuss how Wilson and Szasz would each respond to mandatory drug testing in the workplace and on college campuses.
5. Studies show that people under twenty-five are more likely to binge on drugs and alcohol than people over twenty-five. Are people who engage in excessive drug and alcohol use simply morally immature? Support your answer in light of Lawrence Kohlberg's and Carol Gilligan's stages of moral development. If moral immaturity is a factor in drug and alcohol abuse, discuss how this knowledge might be incorporated into a policy on your campus regarding drug use and drug education.

DOUGLAS N. HUSAK

A Moral Right to Use Drugs

Douglas Husak is a professor of philosophy at Rutgers University. In this article he critically analyzes the various arguments against drug use, including those based on harm and the virtue-based argument of James Q. Wilson. Husak concludes that there is nothing inherently immoral about drug use, apart from any harm it may cause. Instead of outlawing drugs, we should use drug education programs to combat harmful use.

Critical Reading Questions

1. According to Husak, what is the current status of the "war on drugs"?
2. According to Husak, why has a war been declared on illegal drugs?
3. What is a "drug" and why is this term, as it is commonly used, confusing?
4. What is a "recreational drug"? How does it differ from a "nonrecreational drug"?
5. What have been some of the consequences of the "get-tough" policy on drugs?
6. What are some of the arguments for the criminalization of drugs?
7. Why does Husak reject Wilson's argument against the legalization of drugs?
8. What is the difference between maintaining that adults have a right to use drugs and advocating drug use?
9. What are the similarities, according to Husak, between his position on drugs and the pro-choice position on abortion?
10. What policy does Husak suggest regarding drug abuse?

Accurate or not, the perception that drug use is out of control has triggered an enormous state response. Illegal drugs have become the single most important concern of our criminal justice system. Although estimates are imprecise, tens of billions of dollars are probably spent to enforce LAD [laws against drugs] every year, and the less direct costs of the war on drugs are several times greater. . . .

About 750,000 of the 28 million illegal drug users are arrested every year. Between one-quarter and one-third of all felony charges involve drug offenses. . . . As a result, courts have become clogged, and prison overcrowding is legendary. The U.S. Sentencing Commission has estimated that within fifteen years the Anti-Drug Abuse Act passed by Congress in 1986 will cause the proportion of inmates incarcerated for drug violations to rise from one-third to one-half of all defendants sentenced to federal prison. The costs of punishment threaten to drain the treasury, as each prisoner requires expenditures of between $10,000 and $40,000 per year. Since the average punishment for a drug conviction has risen to seventy-seven months in prison, each new inmate will cost taxpayers approximately $109,000 for the duration of the sentence.

Law enforcement officials continue to exercise broad discretion in arresting and prosecuting

---

"A Moral Right to Use Drugs," in *Drugs and Rights* (New York: Cambridge University Press, 1992), 10–12, 14–18, 20–21, 44–45, 50–51, 56–60, 63–68, 251–256. Some notes have been omitted.

drug offenders. More than three-quarters of those arrested are eventually charged with possession, typically of marijuana. Many crimes of possession involve amounts that include a presumption of intent to distribute. Sometimes the quantity of drugs that creates this presumption is small. . . .

The true extent of the war on drugs cannot be measured in quantities of dollars spent or numbers of defendants punished. The enforcement of drug laws has diminished precious civil liberties, eroding gains for which Americans have made major sacrifices for over two centuries. Increasingly common are evictions, raids, random searches, confiscations of driver's licenses, withdrawals of federal benefits such as education subsidies, and summary forfeitures of property. . . .

First, why do so many Americans use recreational drugs? Or, more specifically, why do so many Americans use the kinds of recreational drugs of which the majority disapproves? The power of drugs per se can only be part of the explanation. Illegal drug use is less prevalent in many countries where drugs are plentiful, inexpensive, and higher in quality than those available in America. A more viable strategy to combat drugs might attempt to identify and change the conditions peculiar to America that have led to widespread use. . . . It is hard to see how a long-term solution to the drug problem can be found without knowing why so many Americans are motivated to break the law in the first place. . . .

A second issue is typically neglected in understanding and evaluating the war on drugs: Why has war been declared on illegal drugs? The simplistic answer is that drugs pose a threat to American society comparable to that of an invading enemy. Self-protection requires the mobilization of resources equivalent to those employed in time of war. For reasons that will become clear, I do not believe that this answer can begin to explain the extraordinary efforts of the state in combating drugs. Few wars—and certainly not the war on drugs—can be understood as a purely rational response to a grave social crisis. . . .

The public fears that America is a nation in decline. Crime, poverty, poor education, corporate mismanagement, and an unproductive and unmotivated work force are cited as evidence of this deterioration. Who, or what, should be blamed? The political climate limits the range of acceptable answers. Conservatives will not allow liberals to blame institutional structures for our problems. The difficulty cannot be that government has failed to create the right social programs to help people. Nor will liberals allow conservatives to blame individuals for our problems. The difficulty cannot be that people are lazy, stupid, or egocentric. What alternative explanations remain?

Illegal drugs provide the ideal scapegoat. Drugs are alleged to be so powerful that persons cannot be blamed very much for succumbing to them, as they could be blamed for not studying or working. And drugs are so plentiful and easy to conceal that government cannot be blamed very much for failing to eliminate them. Even better, most drugs are smuggled from abroad, so Americans can at-tribute our decline to the influence of foreigners. In blaming drugs, politicians need not fear that they will antagonize a powerful lobby that will challenge their allegations and mobilize voters against them. Almost no organized bodies defend the interests of drug users. Illegal drugs represent a "no-lose" issue, the safest of all political crusades.

A scapegoat would be imperfect unless there were at least some plausibility in the accusations of drug prohibitionists. Perhaps illegal drug use *has* increased crime, contributed to poverty, exacerbated the decline of education, and decreased the productivity of workers. Sometimes it may have done so in dramatic ways. The stories of the most decrepit victims of drug abuse lend themselves to biographies and television docudramas that make a deep and lasting impression on viewers. Everyone has seen vivid images of persons who were driven by drugs to commit brutal crimes, abandon their children, steal from their friends, drop out of school, stop going to work, and perhaps even die. In light of these consequences, who can condone illegal drug use? . . .

A third and final issue about the war on drugs raises a matter that I will explore in greater depth:

If there is to be a war on drugs, against which drugs should it be waged? . . .

How is "drug" defined by those who make the effort to define it at all? The answer depends on the discipline where an answer is sought. Perhaps the most frequently cited medical definition is "any substance other than food which by its chemical nature affects the structure or function of the living organism." Undoubtedly this definition is too broad. Nonetheless, I tentatively propose to adopt it until a better alternative becomes available.

Notice that this definition refers only to the pharmacological effect of a substance and not to its legal status. For two reasons, "drugs" must not be defined as synonymous with "illegal drugs." First, it would be absurd to suppose that a non-drug could become a drug, or that a drug could become a non-drug, simply by a stroke of the pen. A legislature can change the legal classification of a substance, but not the nature of that substance; it has no more power to decide that a substance is a drug than to decide that a substance is a food. Second, a philosophical study designed to evaluate the moral rights of drug users can hardly afford to rely uncritically on the existing legal status of substances, since the legitimacy of these determinations is part of what is under investigation. To suppose that "drugs" means "illegal drugs" begs important questions and concedes much of what I will challenge. In what follows, I will use the word "drug" to refer to both legal and illegal substances that satisfy the medical definition I cited.

No doubt this usage will create confusion. Despite the desirability of distinguishing "drugs" from "illegal drugs," there is ample evidence that the public tends to equate them. Surveys indicate, for example, that whereas 95 percent of adults recognize heroin as a drug, only 39 percent categorize alcohol as a drug, and a mere 27 percent identify tobacco as a drug. This tendency is pernicious. The widespread premise that only illegal substances are drugs lulls persons into accepting unsound arguments such as the following: Drugs are illegal; whatever is illegal is bad; we drink alcohol; what we do isn't bad; therefore, alcohol is not a drug. Clear thinking about this issue is impossible unless one realizes that whether a substance is a drug is a different question from whether that substance is or should be illegal. . . .

RECREATIONAL DRUG USE

As the examination of the Controlled Substances Act demonstrates, war has not really been declared on *drugs*. War has been declared on persons who make a certain *use* of drugs. I will describe this use as *recreational*.

By "recreational use," I mean consumption that is intended to promote the pleasure, happiness, or euphoria of the user. . . . Interviews with users indicate that they are most likely to consume drugs on two general occasions. First, they use drugs to attempt to improve what they anticipate will be a good time. Hence drug use is frequent during parties, concerts, and sex. Second, they use drugs to attempt to make mindless and routine chores less boring. Hence drug use is frequent during house cleaning and cooking. I regard these as paradigm examples of recreational use. . . .

The concept of recreational use can be clarified by contrasting it with other purposes for using drugs. The most familiar nonrecreational reason to use drugs is medical. Although most drug use is either recreational or medical, these categories do not begin to exhaust the purposes for which drugs are consumed. Some persons take drugs for the explicit purpose of committing suicide. Others take drugs ceremonially, in the course of religious rituals. Still others take drugs in order to enhance their performance in competitive sports. . . .

Undoubtedly my focus on recreational drug use will give rise to the criticism that my approach is academic, middle-class, and unresponsive to the realities of drug use in impoverished neighborhoods. Drug use in ghettos, it will be said, is not recreational. The less fortunate members of our society do not use drugs to facilitate their enjoyment at concerts but to escape from the harsh realities of their daily lives. Here, at least, gloom and despair play a central role in explaining the high incidence of drug use. . . .

The empirical facts are ambiguous in proving that illegal drug use is a special problem for the black community. Only 20 percent of all illegal drug users are black. Whites are more likely than blacks to have tried illegal drugs, and cocaine in particular, at some time in their lives. The more drug prohibitionists succeed in portraying drug use as a ghetto phenomenon, born of frustration and despair, the easier it is to lose sight of the repudiation of liberal values that LAD entails. As I will emphasize time and time again, too much of our policy about illegal drug use is based on generalizations from worst-case scenarios that do not conform to the reality of typical drug use. I hope to undermine the inaccurate stereotypes of drug use and drug users reinforced by this objection. LAD prohibits drug use by members of all races and classes; a legal policy applicable to all should not be based on the perceived problems of a few.

THE DECRIMINALIZATION MOVEMENT

. . . Courts and jails have become clogged as a result of "get-tough" policies toward drug offenders. . . . In many jurisdictions, delays in criminal cases not involving drugs or in the adjudication of civil disputes have become intolerable. The number of Americans behind bars has recently exceeded the one million mark and sets new records every day. . . . As a result of overcrowding by nonviolent drug offenders, violent criminals are less likely to serve long prison terms. . . .

Among the more serious effects of prohibition is discrimination against the poor, who increasingly consume a higher and higher percentage of illegal drugs. Although two-thirds of weekly drug users in New York State in 1987 were white, 91 percent of the persons convicted and sentenced to state prison for drug-related offenses were either black or Hispanic. Therapeutic treatment is frequently provided for middle- and upper-class users; prison is the preferred mode of "treatment" for the underprivileged. . . .

Finally and most significantly, the war on drugs is counterproductive in making criminals of tens of millions of Americans whose behavior is otherwise lawful. Most drug users are lucky to escape detection. Others are less fortunate. . . . Even those who are eventually acquitted spend tremendous sums of time and money defending themselves in court. . . .

ARGUMENTS FOR CRIMINALIZATION

Defenses of and attacks against arguments for decriminalization have become so familiar that it is easy to forget that the burden of proof should be placed on those who favor the use of criminal penalties. When arguing about criminalization, most philosophers begin with a "presumption of freedom," or liberty, which places the onus of justification on those who would interfere with what a person wants to do. . . .

A second and equally familiar presumption cuts in the opposite direction. A "presumption in favor of the status quo" allocates the burden of proof on those who oppose any change in current laws against the use of recreational drugs. No one has any clear idea about what weight to assign to these "clashing presumptions." For this reason, it is probably unproductive to worry too much about who should bear the burden of proof on this issue. . . .

I assume without much argument that a respectable defense of criminal legislation must demonstrate that it is needed to prevent *harm*. Everyone agrees that persons lack a moral right to cause harm, so criminal laws that prohibit harmful conduct do not violate the basic principles I have described. . . . But in the absence of harm, criminal sanctions are undeserved and unjustified.

The least controversial rationale in favor of criminalization is that the conduct to be prohibited is harmful *to others*. Many legal philosophers, following the lead of [John Stuart] Mill, believe that harm to others is a necessary condition that any criminal law must satisfy in order to be justified. . . . A more

controversial rationale in favor of criminalization is that drug use should be prohibited because it is harmful *to users* themselves. . . .

Many philosophers are quick to point out that "no man is an island" and that whatever harms oneself also harms others or at least is capable of doing so. Perhaps there are no examples of "pure" or "unmixed" paternalism, that is, of an interference with liberty that is justifiable solely on the ground that the conduct to be prohibited harms the doer. I do not maintain otherwise. I do not suppose that a given activity can harm the doer but not others. The distinction between harm to oneself and harm to others is *not* a distinction between kinds of laws, but rather it is a distinction between *rationales* for laws. Any law might be defended by more than one rationale. . . .

My premise that the use of the criminal sanction should require harm can be questioned. Perhaps arguments can be marshaled in support of LAD that do not depend on harm, either to oneself or to others. According to *legal moralism*, the wrongfulness of conduct per se, apart from its harmful effects, is a sufficient reason to impose criminal punishment.

Many drug prohibitionists resort to legal moralism in support of LAD. [William] Bennett [drug czar under President George H. W. Bush] replies to the cost-benefit analyses of decriminalization theorists as follows: "I find no merit in the legalizers' case. The simple fact is that drug use is wrong. And the moral argument, in the end, is the most compelling argument." There can be no doubt that popular objections to illegal recreational drug use are often couched in the strongest possible moral terms. Drug use is frequently portrayed as sinful and wicked. . . .

For two reasons, however, I will have little to say about legal moralism here. First, this principle is extremely problematic. No one has presented a compelling case in favor of legal moralism; responses from philosophers have been almost entirely negative. One recurrent theme of their attack is that legal moralism might be used to enforce community prejudice. The requirement that criminal liability presupposes a *victim* who has been *harmed* helps to assure that persons will not be punished simply for doing what those with political power do not want them to do.

Second, the application of legal moralism to LAD is utterly baffling. Why would anyone believe the drug use per se is immoral, apart from any harm it might cause? . . .

What, exactly, do drug prohibitionists believe to be immoral about recreational drug use? Two alternatives are possible. Does the alleged wrong consist in the act of drug use per se, or in the alteration of consciousness that drug use produces? The former alternative seems unlikely. Suppose that the physiology of persons were altered so that a given drug no longer produced any psychological effect. Could anyone continue to believe that the use of that drug would still be immoral? In any event, contemporary Americans widely reject the view that the act of drug use is inherently wrong. Few condemn the moderate use of alcohol. . . .

The latter alternative seems no more attractive. Why should the alteration of consciousness produced by drug use be immoral, apart from any harm that might result? Some theorists have proposed that practices such as long-distance running and meditation can trigger natural neurological reactions that alter consciousness in respects that are phenomenologically indistinguishable from the effects of drug use. No one has suggested that such practices are immoral, and for good reason. . . .

Perhaps many Americans share a vague conviction that some but not all ways of altering consciousness, by the use of some but not all drugs, is immoral. If this conviction could be defended, the particular experience of alcohol intoxication might be upheld as morally permissible, whereas the experiences of intoxication produced by various illegal drugs could be condemned. As it stands, however, this conviction is a conclusion in search of an argument. Typically, persons appeal to harm, either to oneself or to others, in attempts to differentiate between intoxication from alcohol

and intoxication from illegal drugs. In this guise, the argument should be taken seriously. . . .

Moral objections to drug use might also be derived from an ideal of human excellence. Drug use might not be conducive to the attainment of a particular conception of virtue. These arguments are frequently endorsed by drug prohibitionists. According to Bennett, "Drug use degrades human character, and a purposeful, self governing society ignores its people's character at great peril." James Q. Wilson confines his virtue-based arguments to illegal drugs: "Tobacco shortens one's life, cocaine debases it. Nicotine alters one's habits, cocaine alters one's soul." What conception of virtue is employed here? . . . According to this tradition, drug use, like any other recreational activity, is suspect. Recreational activities are nonaltruistic and self-indulgent. . . .

The answer is that virtue-based arguments fail to support criminal punishment for recreational drug use. Bennett is correct that a society should not "ignore its people's character." But it does not follow that the protection of character is an appropriate objective of the criminal law. The prohibitions of the criminal law describe the minimum of acceptable behavior beneath which persons are not permitted to sink. Virtue-based considerations cannot be used to show that moderate self-indulgence, as well as any temporary impairment of rationality and autonomy brought about by most incidents of drug use, fall below this permissible level. The criminal law should not enforce a particular conception of human excellence, however attractive it may be. . . .

MISINTERPRETATIONS

I have concluded that the arguments in favor of believing that adults have a moral right to use drugs recreationally are more persuasive than the arguments on the other side. . . .

First, the conclusion that adults have a moral right to use drugs recreationally does not amount to advocating drug use. . . . This basic distinction is widely appreciated in most other contexts. Adults have the moral right to preach communism or to practice Buddhism. Yet no one who defends this right would be misunderstood to recommend a conversion to communism or Buddhism.

Nonetheless, one of the most widely voiced objections to the proposal to repeal LAD is that it would express the wrong symbolism about drug use, especially among adolescents. . . .

In order to dispel the impression that support for a right to use drugs is tantamount to encouraging drug use, those who reject LAD should be described as endorsing a *pro-choice* position on recreational drug use. This label has been carefully crafted by persons who uphold the right of women to terminate their pregnancies. These persons are not "pro-death," or "anti-life," as their critics would like the public to believe. Perhaps many of them would not elect abortion as their own solution to an unwanted pregnancy. Still, they believe that women have the right to make this choice for themselves. Misunderstanding would be avoided if the debate about the decriminalization of recreational drug use borrowed this terminology. The conclusion that adults have a moral right to use drugs recreationally should be described as the pro-choice position on recreational drug use. . . .

Should the rights of adults be infringed in order to ensure that the wrong message is not received by the public (to whom this argument extends very little credit)? The main problem is that this rationale for LAD would not allow the decriminalization of *any* activity that is less than exemplary. At bottom, this argument is simply another utilitarian defense of the status quo. The rights of some adults should not be sacrificed so that others do not misinterpret a message. . . .

A second related but distinct misunderstanding of my position is as follows. The conclusion that adult use of recreational drugs is protected by a moral right does not entail that drug use is beyond moral reproach. The exercise of a moral right may be subject to criticism. Perhaps all recreational drug use, legal and illegal, is morally tainted. . . . In any event, some instances of recreational drug

use are morally objectionable, beyond those in the special circumstances in which users create an impermissible risk of harm to others. These objectionable instances might be described by the pejorative term *drug abuse*. . . .

If the moral right to use drugs recreationally is to be respected, the need to minimize disutility leaves society with little choice but to discourage drug abuse. The process by which this goal is reached might loosely be described as "drug education." But this process differs from drug education as it is usually conceived. Most educational programs are prevention programs. As so designed, education has generally been deemed a failure, largely because it has not been shown to achieve its objective of decreasing drug use. Yet there may be more reason for optimism if the goal of education is to decrease drug abuse.

As so construed, drug education may never have been tried. No existing educational program has attempted either to separate use from abuse or to indicate how abuse might be avoided by means other than abstinence. The introduction of scientifically respectable materials in drug education programs has been politically unacceptable. . . .

Since I make no attempt to solve America's drug problem as a matter of social policy, I will hazard only one final observation about the prospects for success that drug education as so conceived will minimize drug abuse. To demand that recreational drug users show restraint over the time, place, and quantity of their consumption is not to require the impossible. In fact, virtually every drug user exhibits some degree of control over her consumption. The means by which users manage to avoid abuse deserves careful study and extensive publicity. Perhaps a successful educational program should seek out responsible drug users. . . . To respect the moral right of adults to use recreational drugs may be painful, at least in the short run. But the protection of moral rights has a value to Americans that is not easily expressed in the utilitarian calculus of costs and benefits in which the decriminalization debate is usually cast.

Discussion Questions

1. Former Virginia Governor L. Douglas Wilder proposed mandatory drug testing of all college students. Discuss some of the moral arguments for and against Wilder's proposal. Develop a policy on drug testing for your campus. What might some of the objections be? Discuss how you would defend your policy against objectors.
2. Does Husak present a convincing rebuttal of James Q. Wilson's argument against the legalization of drugs? Discuss how Wilson might respond to Husak's criticism.
3. Critically analyze Husak's comparison of the right to use drugs and the pro-choice position in the abortion debate.
4. Discuss Husak's argument that drug education, rather than LAD, is the best policy for dealing with drug abuse. Discuss also what sort of drug education program would be most effective on your campus.
5. Florida State University in Tallahassee is one of many colleges working with local police and businesses to reduce alcohol abuse by its students. Recently, a bar near the university put on a "Valentine's Day 'No date, get drunk! Free beer all night.'" The event was advertised at the college. Discuss how universities should respond to this type of aggressive advertising aimed at college students as well as what stance would Wilson and Husak each most likely take.

LAURA DEAN-MOONEY AND JOHN MCCARDELL

Two Takes on the 21 Drinking Age

Laura Dean-Mooney, national president of Mothers Against Drunk Driving, and John McCardell, vice chancellor of the University of the South in Tennessee, debate the wisdom of keeping the drinking age at twenty-one or lowering it to age eighteen. In particular, they debate the question in the context of the Choose Responsibility initiative signed by nearly 130 college and university presidents stating that the current legal drinking age of twenty-one contributes to a culture of binge drinking on campuses.

Critical Reading Questions

1. What evidence does Laura Dean-Mooney present to support her conclusion that the drinking age should remain at age twenty-one?
2. According to Dean-Mooney, why is drinking harmful to young adults?
3. On what grounds does McCardell oppose legislation setting the drinking age at twenty-one?
4. What evidence does McCardell use to support his conclusion that raising the drinking age from eighteen to twenty-one has not been effective in curbing problem drinking on college campuses?
5. What solution does McCardell put forth to curb problem drinking on college campuses?

A Lower Age Would Be Unsafe

LAURA DEAN-MOONEY

As the fall semester begins at colleges across the country, campuses once again face the challenge of combating underage and binge drinking. This is a serious and difficult issue for colleges, for communities, and for parents like me who are preparing to send a son or daughter to college.

Unfortunately, more than 100 college presidents have chosen to address the issue by signing on to a misguided initiative that ostensibly favors a debate but is supported by a group, Choose Responsibility, whose sole aim is lowering the drinking age from 21 to 18 years old. Mothers Against Drunk Driving is open to a discussion about solving the problems of underage and binge drinking. But the discussion must be based on facts, and, in this case, the facts are clear: 21 saves lives.

Since states began setting the legal drinking age at 21, the law has been one of the most studied in our history. The evidence is overwhelming: More than 50 high-quality scientific studies all found the 21 law saves lives, both on and off the road. And the public agrees: 72 percent of adults think that lowering the drinking age would make alcohol more accessible to kids, and nearly half think that it would increase binge drinking among teens, according to a new Nationwide Insurance poll.

This is why stakeholders from scientific, medical, and public health organizations have joined

U.S. News & World Report (September 15/22, 2008), 10–11.

MADD to form the Support 21 Coalition: We believe in basing public health policy on sound medical research and are committed to highlighting the lifesaving impact of the 21 drinking age.

Twenty-one isn't just an arbitrary number set by Congress—more than 20 states already had laws setting the drinking age there in 1984. And since the 21 law was widely enacted, the number of young people killed annually in crashes involving drunk drivers under 21 has been cut in half, from more than 5,000 individuals in the early 1980s to around 2,000 in 2005. By the end of 2005, the 21 drinking age had saved nearly 25,000 American lives—approximately 1,000 lives a year.

The Support 21 Coalition stands behind the indisputable scientific research that demonstrates lowering the drinking age would make the difficult problems of underage and binge drinking far worse. Research indicates that when the minimum legal drinking age is 21, people under age 21 drink less overall and continue to do so through their early 20s. When the drinking age has been lowered, injury and death rates significantly increased.

Lowering the age of those who have easy access to alcohol would shift responsibility for underage drinking to high school parents and educators.

A neurotoxin. Research has shown that the harmful effects of alcohol abuse are magnified on a teenager's still-developing brain. The adolescent brain is a work in progress, marked by significant development in areas of the brain responsible for learning, memory, complex thinking, planning, inhibition, and emotional regulation. The neurotoxic effect of excessive alcohol use is a danger to these key regions of the maturing adolescent brain.

A person's brain does not stop developing until their early to mid-20s. During this period, alcohol negatively affects all parts of the brain, including cognitive and decision-making abilities as well as coordination and memory. Adolescent drinkers not only do worse academically but are also at greater risk for social problems like depression, violence, and suicidal thoughts.

Lowering the drinking age would have dangerous long-term consequences: Early teen drinkers are not only more susceptible to alcoholism but to developing the disease earlier and more quickly than others.

The problem of binge drinking on college campuses needs to be addressed, but lowering the drinking age would be not only short-sighted but deadly. The simple fact is that the 21 law saves lives and is, therefore, nonnegotiable.

The Status Quo Has Bombed

JOHN MCCARDELL

It is time to rethink the drinking age. That's the message of nearly 130 college and university presidents who have signed on to the Amethyst Initiative, which declares that the 21 drinking age does not work and has created a culture of binge drinking on campus. While the initiative intentionally does not prescribe a specific new policy, it seeks a debate that acknowledges the current law's failure. (As a former college president, I am not a signatory, but I have helped spearhead the effort.)

The National Minimum Legal Drinking Age Act could not, constitutionally, mandate a national drinking age. Instead, it allowed the states to set the age as they chose. If, however, the age was lower than 21, the state would forfeit 10 percent of its federal highway appropriation.

End of debate. Until now.

As the discussion renews in earnest throughout the media and society, "science" will be used to support the status quo. Yet any survey of the evidence at hand shows that the data are peskily inconsistent. The National Institute on Alcohol Abuse and Alcoholism, a respected authority, believes that the 21-year-old drinking age works. Yet its website reveals that of 5,000 Americans under the age of 21 who die of alcohol-related causes each year, only 1,900 are traffic fatalities, meaning the remaining 3,100 occur *off* the highways. Drunk teens behind the wheel are less of a problem than those drinking in private.

And drinking continues to be widespread among adolescents: The institute says that 75 percent of

12th graders, two thirds of 10th graders, and two fifths of eighth graders have consumed alcohol. Not surprisingly, the institute concludes that we have an "enormous public health issue." The Institute of Medicine notes that "more youth drink than smoke tobacco or use illegal drugs." The estimated annual social cost of underage drinking is $53 billion. These statistics will most likely not be offered in support of the current law.

Moreover, the evidence that raising the drinking age has been primarily responsible for the decline in alcohol-related traffic fatalities (a trend that effectively stopped in the mid-1990s and has been inching upward) is underwhelming. One survey of research on this subject revealed that about half of the studies looked at found a cause-and-effect relationship between the 21 drinking age and diminishing alcohol-related traffic fatalities—and half showed no relationship whatsoever.

Hidden drinking. Yet college presidents are pilloried for daring to question our current laws. Even though many students who enter their institutions have already consumed alcohol, the presidents are labeled "shirkers" and "lawbreakers" for not enforcing an unenforceable law. The more they crack down on campus drinking, the more they simply force that behavior into clandestine locations, often off campus, beyond their sight and their authority.

Where, after all, does "binge drinking" take place? Not in public places, from which the law has effectively banned alcohol consumption, but in locked dorm rooms, off-campus apartments, farmers' fields, and other risky environments.

The "abstinence" message—the only one legally permissible—is failing, as prohibition has always failed. Presidents looking for a solution find such remarkable documents as the 2002 "Call to Action," written by a National Institutes of Health task force, which advises presidents to, in effect, break the law. It describes programs to "reduce," not eliminate, alcohol consumption. It recommends teaching "students basic principles of moderate drinking." In short, it advises what others have condemned.

Effective laws reflect not abstract, unattainable ideals but rather social and cultural reality. The reality in this case is that one is a legal adult at age 18; that alcohol is present in the lives of young adults ages 18 to 20; that most of the rest of the world has come out in a very different place on this issue; and that the 21-year-old drinking age is routinely evaded. Either we are a nation of lawbreakers, or this is a bad law.

Discussion Questions

1. Critically analyze the arguments presented by Dean-Mooney and by McCardell. Which person presents the stronger argument and why?
2. The United States has the highest legal drinking age in the world. In most of the world, the legal drinking age is sixteen or eighteen; some countries, such as Portugal and China, have no minimum age. Is this information relevant to the debate over the legal drinking age in the United States? Use research to support your answer.
3. One of the most common arguments for lowering the drinking age is that eighteen-year-olds in the United States are able to legally marry, drive a car, hunt, and serve combat duty in the military. Discuss whether it logically follow from this that they should also be permitted to drink alcohol.
4. Does a prohibition of drinking on campus make it more likely or less likely that you and others you know will drink? Discuss what effect lowering the drinking age would have on your drinking behavior and that of other students.
5. Research the policy on your campus regarding drinking. Working in small groups come up with a policy that you think would be most effective in curbing binge drinking on your campus.