# HEROIN DECRIMINALIZATION AND THE IDEOLOGY OF TOLERANCE: A CRITICAL VIEW

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Proposals for the decriminalization of heroin are examined and then analyzed in terms of the ideology of tolerance which informs anti-psychiatry, labeling sociology, and the concept of the victimless crime. Marcuse's discussion of repressive tolerance is brought to bear on this issue in order to suggest that tolerance for deviance may have consequences not immediately expected by those who advance reformist proposals regarding narcotics policy.

> *Thus man was not liberated from religion; he received religious liberty. He was not liberated from property; he received the liberty to own property. He was not liberated from the egoism of business; he received the liberty to engage in business.* [Marx, 1963:29]

## I

The law enforcement model of heroin control appears unable to generate policies that can stem the spread of heroin use. The social cost of prevailing practices is a matter of deep concern. It is therefore not surprising that the initiative in contemporary discussion of the "drug problem" has been seized by those who argue for the "decriminalization" of narcotics and other drugs. In both law review articles and other media this has been a recurrent theme during the past several years:

> The laws which make addiction illegal create the public enemy we so fear. [Slade, 1974:26]
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> Heroin continues to be a significant social problem, not because of any intrinsic quality . . . but because it is the subject of a national criminal prohibition. [Israel and Mogill, 1975:284]
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> The assumptions underlying the criminalization of narcotics and psychotropic substances must be examined. It is clear that drug use will be with us as long as people want to use drugs. The legal system cannot prohibit such a desire and it must defer to other disciplines to understand the reasons for this desire and to create methods to stem it. [Cooper, 1975:989]

Although all proposals for decriminalization criticize the application of state sanctions to those who possess narcotics for personal consumption, both on grounds of social utility and concern for the personal welfare of the heroin user, there is a striking lack of agreement concerning the core issue of how to respond to those who wish to, or feel they must, use heroin. The

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call for decriminalization is sufficiently ambiguous that it can provide a unifying theme for those who support: (1) the elimination of criminal sanctions for those charged with possession of narcotics for personal use, but not legal access to heroin; (2) the prescription of maintenance dosages of heroin by physicians to those already addicted; (3) the prescription of dosages of heroin by physicians to those who, though not addicted, desire to use that narcotic; (4) the over-the-counter sale of heroin to any adult. Adoption of the first course would necessitate little more than ending the haphazard and irrational pattern of current enforcement.[1] The second alternative, often denominated a "clinic system," would add heroin to methadone as a maintenance drug. The third option retains the physician's role primarily as a way of preserving an aura of therapeutic intervention, though it simultaneously undercuts the reformist argument that "sick" addicts should be provided with heroin as a "medication." The final choice rejects even the pretense of therapeutic intervention, perceiving heroin use as a private choice no different from the decision to consume other intoxicants.

In this article consideration of the second option—heroin maintenance clinics for addicts—and its very important limitations will provide the framework for a discussion of the last alternative, the "liquor store" model of heroin distribution. The analysis of these proposals will be tied to a critique of current efforts to control discordant behavior, which I shall refer to as the ideology of tolerance. This ideology, and the justifications for decriminalization, will then be discussed in terms of Marcuse's argument about the potentially repressive function of tolerance.

## II

Calls for the decriminalization of addiction are most often accompanied by proposals for the adoption of a "clinic system" for the distribution of heroin to addicts. Such proposals typically allude to a poorly understood version of the British approach to narcotics as offering an appropriate model for reformist emulation.[2] Underlying such suggestions for medical control of the dis-

1. Robert Dupont, Director of the National Institute on Drug Abuse, is reported as having said, "If what you mean by decriminalization is the sale of drugs, I have no sympathy. I want to use the full force of the law against all sellers. . . . But if decriminalization means possession it's already well advanced . . . there are almost no arrests for possession of these drugs on a Federal Level" (Arnold, 1976:6). In San Francisco, Inspector Cecil Pharris of the Police Narcotics Bureau stated: "We don't really get involved in simple possession by users even with heroin" (*U.S. News and World Report*, 1976).
2. For brief descriptions of the evolution of British narcotics policy see May (1972), Zinberg and Robertson (1972:121-83), and Schur (1962). It is popularly assumed that the British approach involves the widespread pre-

tribution of heroin is the conception of addiction as a psychophysiological disease which (etiological factors aside) requires the chronic administration of maintenance dosages of narcotics to prevent the onset of the withdrawal syndrome.[3] Because the addict feels "sick" when he is deprived of narcotics the prescription of such drugs, in medically determined doses, allows the physician to perform the therapeutic function of reducing physiological discomfort while assisting the patient to function normally. Like other disorders characterized by "deficits"—for example, diabetes—the medical authority seeks to manage the disease rather than to cure it, since cure may not be possible. This explains the indeterminate duration of treatment in narcotic maintenance programs.

Proposals incorporating these assumptions have a long history in the United States, beginning immediately after the passage of the Harrison Act (38 Stat. 785, 1914), which was designed to prohibit the nonmedical distribution of narcotic drugs. Since World War II those identified with the liberal wing of the American political spectrum,[4] as well as those specifically concerned with narcotics reforms,[5] have advocated the medical prescription of heroin to addicts. But what is striking is the growth of support for such an approach in recent years.[6] Though there remains considerable resistance even to experiments with heroin in a clinical

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scription of heroin to addicts. Although this was the case when most addicts became addicted in the course of medical treatment, the system has changed dramatically since 1968. As British officials became increasingly concerned over the spread of drug abuse, and as an ever larger proportion of those requesting heroin maintenance were persons who had become addicted in nontherapeutic settings, severely restrictive policies emerged that only permitted designated physicians to prescribe narcotics in special clinics. Most recent discussions of these clinics point to the fact that when British physicians now prescribe narcotics they prefer methadone. "At present, approximately one-third of patients attending clinics for the first time and seeing a doctor receive no prescription of opiates, at least initially; of those who receive a prescription only 16% receive heroin. *The amount presently prescribed to new patients is such that the system can no longer be justifiably regarded as a maintenance system, but rather must be described as an abstinence-oriented system*" (Hawks, 1974:53) (emphasis added). Mitcheson and Hartnall (1977) reflect the growing disenchantment among British medical practitioners.

3. The sedative effects of such medically prescribed drugs are presumably minimized by the development of tolerance. Hence maintenance is not a matter of "doping up" the patient. For a statement of this position see Dole and Nyswander (1967).
4. An analysis of the discussion of the heroin issue in those journals identified with liberal political causes in the years 1960-1973 is contained in Bayer (1975a).
5. Such as Alfred Lindesmith. A discussion of reform proposals advanced during the last three decades is contained in Bayer (1976).
6. In the fall of 1976, considerable publicity was given to a statement by Dr. Peter Bourne, an aide to Jimmy Carter, suggesting that the United States "reexamine the question of whether we ought to *decriminalize* heroin and set up *treatment centers* to dispense heroin" (emphasis added). Additionally the National League of Cities undertook to review such a proposal and the Massachusetts Council of Churches also urged con-

setting,[7] such opposition is increasingly limited to the expression of warnings about technical, operational difficulties such as securing the supply of narcotics, preventing the diversion of heroin to those not entitled to prescriptions, staffing clinics so that they might remain open at least 18 hours a day (Kaplan, 1975). Earlier denunciations of heroin maintenance as a "concession to weakness and defeat"[8] seem like caricatures of ideological rigidity.

Although new vitality seems to have been added to arguments for the medical distribution of heroin, this plan only marginally responds to the dilemma posed for the social order by the substantial number of heroin users who are either not addicted[9] or, if addicted, are uninterested in currently available forms of treatment, including methadone maintenance.[10] Medically supervised heroin maintenance might attract some of those who find methadone unappealing as a maintenance medication,[11] but it fails to respond to those who wish to use heroin in a manner that could only be considered therapeutic with considerable violence to the term.

In order for the medical model of heroin distribution to constitute a viable social policy the population of addicts must be willing to adopt the "sick role" and view dependence upon narcotics as a medical problem requiring the intervention of physicians capable of managing the disease of addiction. The therapeutic efficacy of narcotic maintenance as a technical form of medical

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sideration of a clinic system. Indicative of support for heroin maintenance on the part of those concerned with law enforcement was the report of a San Diego Grand Jury (Arnold, 1976:6). See also Fritchey (1976), Barbara and Morrison (1975).

7. Although somewhat dated, the debate that surrounded the proposal of the Vera Institute of Justice in New York City to undertake a pilot project utilizing heroin in the initial six months of treatment reveals the nature of that opposition, especially on the part of Blacks and Hispanics. See Bayer (1975b).
8. Statement of Richard Nixon contained in the files of the Vera Institute of Justice, New York City.
9. After a careful evaluation of the available data, Hunt and Chambers (1976:113) conclude: "The question is not whether there are three or four million, but that the number is several million rather than several hundred thousand heroin users [both addicted and nonaddicted]." Nonaddicted users include those who are just beginning to use and will either become addicted, stop use, or develop a stable pattern of nonaddictive use, as well as those who have already established such a pattern.
10. One estimate is that "probably only about a third of the active users ever enter treatment" (Hunt and Zinberg, 1976:5). Hunt and Chambers suggest that only about 200,000 different heroin users had been in treatment between 1968 and 1975 (1976:77).
11. Methadone is a long-acting synthetic narcotic that requires only one dose every 24 hours. Because heroin lasts four to six hours maintenance at a clinic would require four to five visits a day. For those concerned with "patient management" the advantage is clear. Furthermore, because methadone can be taken orally the addict's involvement with "shooting up" is broken. From the addict's point of view this also has advantages, since many of the diseases of addiction are associated with intravenous administration. But there are disadvantages as well—methadone does not feel as good. For a description of the underlying premises, see Dole and Nyswander (1965).

intervention in the life of a particular patient can ignore etiological factors since, whatever the causes of addiction, maintenance treatment assumes that narcotic dependence is a tractable disease entity. But it is not possible to ignore the etiology of narcotics use when attempting to explain the limitations of the therapeutic response with respect to the total population of addicts. The extent to which, and the reasons why, addicts are uninterested in treatment can only be understood through an analysis of the social basis of narcotics use. It makes little difference whether one argues that the pharmacological properties of heroin make life less intolerable (Abrams *et al.*, 1968), thus serving a retreatist function,[12] or that the hustling life style of the street addict provides gratification to those who choose to use narcotics, which they could not otherwise obtain (Preble and Casey, 1969). The limitations of the therapeutic response to addiction are determined by the existence of heroin users who choose not to be patients but prefer to continue using heroin whatever the risks and costs.

The passion generated by the debate over whether heroin should be added to a pharmacopia that already includes methadone is thus rather remarkable. That debate serves the (unintended) ideological function of protecting the participants from having to confront the disturbing and essential issue of the relationship between the social basis of heroin use and the limitations of a symptomatic response, allowing them to focus on the narrower problem of fashioning a more attractive and effective therapy.

It is within this context of the structurally determined limitations on the therapeutic response to addiction that it is most useful to examine the proposals for moving beyond the medicalization of narcotics use to a free market in which adults would be able to purchase heroin as they now can purchase alcohol. Although the constituency supporting such an option is limited by concern for its social costs, including the almost certain expansion of heroin use and addiction,[13] it is incorrect to assert that "not even the most

12. Merton (1957:153-54) develops the concept of addiction as pharmacological quietism. His theory received important elaboration in Cloward and Ohlin (1960:161-86).
13. John Kaplan has written: "It would thus seem that the uncertainty as to both the consequences of heroin addiction and the projected extent of addiction are such that no responsible formulator of public policy should advocate free availability of heroin *in preference even to the current* seriously deficient legal scheme" (1975:815). In a discussion of the potential social costs of a free-market scheme that he refers to as "decriminalization" Mark A. Deininger has stated: "Heroin is not suited to decriminalization. For although the long-term demand of the addict population is decidedly inelastic, non-addict demand may be elastic at low prices; hence, decriminalization might spark a heroin epidemic induced by cheap heroin" (1976:600).

zealous advocate of decriminalization supports complete legalization" (Wilson *et al.*, 1972:26).

The most noteworthy proponent of the "liquor store" model of heroin distribution is Dr. Thomas Szasz, the iconoclastic opponent of the American psychiatric establishment. His arguments for a free market in heroin have frequently accompanied his broader attack on prevailing conceptions of "mental health and illness" (1970a:208; 1970b:222). Szasz rejects the application of medical terminology to drug use as he rejects its application to other behavioral aberrations. Addiction is not a disease, and the addict is not sick. Defining narcotics use and dependence in such terms merely facilitates the unwarranted expansion of the "therapeutic state."[14] Rejecting the psychological and sociological determinism that perceives the addict as the victim of circumstances,[15] he sees the decision to use heroin as a free choice—a manifestation of personal freedom.[16]

Szasz's first fully developed statement on addiction appeared at the height of anxiety about the "heroin epidemic," in an article entitled "The Ethics of Addiction" (1972). With characteristic zeal and disarming simplicity he equated the right to seek ideas in the market place with the right to seek drugs (ibid.: 75). The effort to impose social control over drug use was a "collectivist" assault on the principle of liberty in America (ibid.: 79).

This brief attack was elaborated into a book-length polemic two years later, with the publication of *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers* (1974). Using imagery drawn from the history of religion, Szasz argued in typically hyperbolic fashion:

> What exists today is nothing less than a worldwide quasi-medical pogrom against opium and the users of opiates. [ibid.: 45]
> I regard tolerance with respect to drugs as wholly analogous to tolerance with respect to religion. [ibid.: 53]

Starting from the atomistic principles of philosophical individualism Szasz has arrived at the view that all the socially disruptive

14. "In the therapeutic state towards which we appear to be moving the principle requirement for the position of Big Brother may be an M.D. degree" (1970b:139). For a full statement on the "therapeutic state" see Szasz (1977:118-33).
15. "Addiction is not a form of genocidal execution . . . it is an expression of self-determination" (Szasz, 1974:15).
16. I have tried to show that the view which a society and the individuals in it hold concerning the use and avoidance of drugs depends in very large part on whether people regard their reasons for ***doing what they want to do*** as temptations or as impulses. In the first case, the subject is a culprit or malefactor and those he injures are his victims; whereas in the second, the subject is not a subject at all but an object containing, as it were, a bundle of irresistible impulses: hence he is himself the victim. [Szasz, 1974:160]

consequences of heroin use can be attributed to the state's effort to impose its version of rectitude ("health") on adult citizens.[17]

The tortured six-year debate within the American Civil Liberties Union over the issue of heroin[18] is instructive because it contrasts so sharply with the simple, unambigous position advocated by Szasz. Although those committed to a Millian dogmatic[19] argued as early as 1970, that "the right to control one's own body includes the right to use and purchase heroin unfettered by the state" (American Civil Liberties Union, 1971:2), the majority of the Board of Directors balked at such an extension of civil libertarian doctrine. Out of a deep concern for the social roots of addiction and the potential impact that the "liquor store" approach would have upon Blacks and Hispanics, they were willing to limit the principle of free choice.[20] When the ACLU advanced a policy in 1976 that appeared to accept the "liquor store" model as part of a general statement on "victimless crimes," it was riddled with contradictions reflective of unresolved ideological tensions.[21]

A different attack on contemporary social practice, though limited in its immediate policy objectives, is more likely to have a profound and radical impact on perceptions of the heroin issue. Dr. Norman Zinberg and his associates, through a series of in-depth interviews with heroin users, have discovered the existence of well established patterns of controlled nonaddictive narcotic use.[22] Undercutting the orthodox assumption that repeated long-term heroin use must lead to compulsive disruptive addiction, the research suggests that under certain circumstances narcotics use

17. We seemed to have learned little or nothing from the fact that we had no problem with drugs until we quite literally talked ourselves into it: we declared first this and then that drug "bad" and "dangerous," gave them nasty names like "dope" and "narcotic," and passed laws prohibiting their use. *The result: our present "problem of drug abuse and drug addiction."* [Szasz, 1974:11] [emphasis added]
18. The course of the debate is detailed in Bayer (1975c).
19. Robert Paul Wolff argues that John Stuart Mill's defense of libertarianism in *On Liberty* was founded on utilitarian principles, specifically abjuring reliance upon "the advantage to be derived from the idea of abstract right." Wolff notes that this contrasts sharply with the contemporary liberal dogmatic assertion of libertarianism as a matter of first principle (1968:3-50).
20. For example, John Sykes, former Chairman of the Wisconsin Civil Liberties Union, wrote to the Board of Directors of the ACLU: "The American Civil Liberties Union has stood alone over the past fifty years as an unyielding defender of individual liberty. For the A.C.L.U. now to suggest, however, as the Biennial Conference would have us do . . . that there should be a constitutional right to destroy one's self by unlimited use of drugs would be a tragic retreat by the A.C.L.U. and its defense of liberty," see Bayer (1975c:467).
21. The resolution stated: "Nothing in this policy is to be construed as placing the A.C.L.U. in opposition to *reasonable* restraint, such as already exists with respect to the production and sale of food, *liquor*, cigarettes, penicillin, insulin, methadone . . ." (Bayer, 1975c:473) (emphasis added). It thus contains the justifications for both the liquor store and medical models of control.
22. For a description of the research project and excerpts from the interviews see Jacobson and Zinberg (1975).

can be integrated into quite conventional life styles.[23]

The consumption of alcohol serves Zinberg as the model for the socially acceptable and "domesticated" use of a powerful psychoactive substance. After examining the ways in which we learn to drink liquor, Zinberg suggests that the ultimate irony of contemporary policy is that it undermines the very cultural processes and social networks that might generate patterns of acceptable heroin use.

> Centuries of experience with intoxicants point clearly to social control not prohibition as the only humane and reasonably successful means of managing their use. Social control means that society permits the use of intoxicants under various legal restraints and develops customs, rituals and social sanctions which define acceptable use. [Zinberg *et al.*, 1975:165][24]

By stressing the possibility that heroin use can be integrated into the social order without disruptive consequences for the user and without subverting socially mandated role expectations, this research obviates the need to argue over the state's right to interfere with the "self destructive" choices of the heroin user.[25] Like the medical model of decriminalization, this research argues that heroin use may be compatible with normal social functioning. Unlike that model, it holds out the possibility of responsible use without the interference of the physician.

Yet because prevailing policies have thwarted the emergence of "customs, rituals and social sanctions" capable of guiding heroin users towards responsible use, Zinberg recognizes that a sudden about-face in social practice might result in serious personal and social disruption. Since the logic of his research and arguments leads to the "liquor store" model of decriminalization he feels compelled to stop short, stating:

> That does not mean that heroin should be openly available at newsstands, but it does mean that heroin maintenance clinics can be tried and an open discussion of the drug's benefits and drawbacks can be begun. [Zinberg *et al.*, 1975:181][26]

Though Zinberg is cautious and extremely modest in advocating any immediate change in policy, the thrust of his work suggests the utility of ultimately moving toward a common social frame-

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23. Particularly interesting is the suggestion that the number of such users may be far greater than one might have expected, see Hunt and Zinberg (1976).
24. For a discussion buttressing this position, which suggests that drug using subcultures develop norms for responsible use, see Young (1972:219).
25. An important step in the debates within the ACLU occurred when the issue of heroin use was linked to the "right" to ruin or take one's own life.
26. It is difficult to conceive of the transition from a medically controlled model to a liquor store model that does not involve a significant rupture. It is not at all clear that the "learning" in the former can provide the "customs, rituals and social sanctions" necessary for responsible use in the latter. It is not sufficient, therefore, to suggest "cautious" first steps.

work for the controlled use of psychoactive substances ranging from alcohol to heroin.

Unlike Szasz, Zinberg does not ignore the social roots of heroin use. In commenting on narcotics use in Vietnam he stated:

> The determining factor in their heroin use had been the intolerable setting in Vietnam, and once they returned to the United States neither the power of the drug nor a susceptible personality proved to be decisive in keeping them drug dependent. [1975:572]

His major concern, however, is not with such primary causes but with society's reaction to heroin use and the consequences of that reaction for the drug user.

> The authors presume drug use and the effects of drug use in our society to be a more complex phenomenon than those who see pharmacological, psychological or social conditions as the primary cause of drug use and drug problems. Particularly, we feel the proponents of a primary cause theory ignore the effect upon personality and life style of someone's being declared and accepting himself as deviant. [Zinberg *et al.*, 1975:175]

The relegation of social and psychological factors to a position of only secondary importance, together with the emphasis upon the possibility of nondisruptive, controlled, integrated use of drugs whether alcohol or heroin, obviates the need to probe the function of such behavior for specific classes within a given social order.

## III

The movement toward decriminalizing drug use, whether limited to the repeal of possession related offenses or expanded to include the elimination of prohibitionist controls, must be considered in the context of the broad ideological attack on efforts to utilize agencies of control (medical and legal) to impose constraints on those whose behavior, though distasteful, poses no direct threat to the property or person of others. This ideology of tolerance has stressed the capacity of American society to absorb a wide range of behavioral differences without a weakening of its normative and institutional foundation. For those concerned with the sociological analysis of deviance the critique has come from the "labeling" school. For those concerned with the medicalization of deviance, the attack is identified with "anti-psychiatry." Finally, for those addressing the issue from a legal perspective, this critique has taken the form of an elaboration of the concept of the "victimless crime."

In defining the orientation of the "labeling" approach to the sociology of deviance John Kitsuse has stated:

> Forms of behavior *per se* do not differentiate deviants from nondeviants. It is the response of the conventional and conforming members of the society who identify and interpret behavior as

> deviant which sociologically transforms persons into deviants. [1962:248]

The task of sociology is to explain the emergence of classifications of deviance, to explore the ways in which such classifications activate particular social responses, and to examine the impact of the process on those so designated. Edwin Lemert (1972:16) has noted that this orientation typically leads to research that takes the perspective of the victimized deviant: the drug user, the alcoholic, the homosexual.

Because they focus on the process by which deviants are designated and on the degradation of those so labeled, researchers and theoreticians of the labeling school have tended to minimize or ignore the etiology, the "root causes," of the behavior labeled deviant.[27] Hence, though this framework can tell us a great deal about the travail of those labeled it cannot and does not seek to explain the prevalence of despised behavior among distinct social classes.[28] It is this which sets the labeling approach apart from the great sociological tradition of Durkheim's *Suicide* (1951) and Merton's *Social Theory and Social Structure* (1957). The impact of labeling theory can be discerned in Anthony Platt's study of juvenile delinquency, which focuses on the middle class orientation of the "child savers" (1969); Joseph Gusfield's study of the temperance movement, which stresses the nativist anti-Catholic basis of the struggle for prohibition (1969); Troy Duster's analysis of the reaction to narcotics use in terms of the class status of users and nonusers (1970); and David Musto's effort to trace the impact of racism on the movement to prohibit drug use (1973).

David Matza has noted that traditional sociological research on deviance has a "correctional" thrust, whereas the labeling school tends to be "appreciative" of deviance. The former has buttressed the policies of those who have sought to rid society of "troublesome activities," whereas the latter has had no such commitment.

> We do not for a moment wish that we could rid ourselves of deviant phenomena. We are intrigued by them. They are an intrinsic vital part of human society (1969:17).

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27. Howard Becker, a central figure in this academic tradition, stated in his seminal book *The Outsiders*: "I will be less concerned with the personal and social characteristics of deviants than with the process by which they came to be thought of as outsiders and their reactions to that judgment" (1963:10).
28. Edwin Schur, whose comparative study of addiction in England and the United States bears the imprint of the labeling school, has acknowledged: "In focusing on the part that reaction processes play in producing deviant outcomes . . . the orientation may indeed (relatively) neglect patterned variations in structural strains and other socioeconomic conditions that at least in part generate the behavior toward which the reactions are initially directed" (1969:314). He has attempted to redress this imbalance, without losing the advantages of this sociological perspective, in *Labeling Deviant Behavior* (1971).

The extent to which "deviant phenomena" represent responses to unbearable social conditions is thus suppressed by this seemingly benign willingness to "appreciate" differing forms of behavior.

While the labeling sociologists have devoted themselves to exposing the value premises of the sociological category of "deviance," anti-psychiatrists like Thomas Szasz and R. D. Laing have sought to reveal the hidden assumptions underlying the "scientific" notion of mental illness.[29] As Peter Sedgwick has noted:

> A number of authors who are critical of current psychiatric theory or practice tend to rest their case on a sharp differentiation which they say can be made between the character of diagnosis in physical illness and the nature of diagnostic classifications in mental illness. The diagnoses of physical medicine refer, on their showing, to objective features of human anatomy or physiology; *whereas the diagnostic operations of the psychiatrist are subjective value-judgments, impregnated with normative and prescriptive elements*. [1974:26] [emphasis added]

Thus by rejecting as pseudo-medical ideology the concept of mental "illness," they have suggested that the psychiatric establishment functions primarily as a guarantor of social order extending control over those whose behavior is merely distasteful or obnoxious. For Szasz mental illness is little more than a myth:

> The notion of mental illness has outlived whatever usefulness it may have had . . . it now functions as a convenient myth. As such it is a true heir to religious myths in general and to the belief in witchcraft in particular.
> . . . we call people mentally ill when their personal conduct violates certain ethical, political and social norms. [1972b:17]

By stripping away the ideology of the "mental health movement," by exposing it as a value-laden distortion of the medical tradition, the anti-psychiatrists have prepared the groundwork for tolerating (integrating into the social totality) behavior that, when denominated "sick" had justified intervention by the social order "in the interest of the patient." Thus Szasz has compared contemporary efforts to compel persons into treatment with earlier attempts to contain "masturbatory insanity."

> Then the psychiatrist was saving the "patient" from masturbation even though he did not want to be saved from it, now the psychiatrist is saving the patient from drug addiction, homosexuality, suicide . . . even though again the victim makes it unmistakably clear by word and act that he does not want to be saved. [1970a:204-5].

If the notion of mental illness is rejected, how do the anti-psychiatrists conceive of the behavior that medicine had diagnosed as "sick"? Laing, whose theory of psychosis is fully cognizant of the extent to which madness is a reaction to the social and psychological environment, has tended to celebrate the schizo-

29. For a perceptive discussion of both Szasz and Laing, see Sedgwick (1972).

phrenic's reality as coequal, or even superior, to that of normal persons.

> Each manifestation of behavior that in orthodox medicine is offered as a "sign" of clinical pathology is taken . . . to be a comprehensible act which, when aligned against its social context, appears eminently reasonable and sane. [Sedgwick, 1971:43]

Although Szasz is less concerned with the environmental determinants of human behavior his stress on the normative element inherent in the choices made by those termed mentally ill tends to minimize the problematic nature of those choices. Seeing them as freely willed, he acknowledges the need for control only when they harm others.

> If psychology and sociology were taken seriously . . . then we would have to conclude two things. First, that insofar as it is always possible to regard antecedent events as explanations of human behavior men should never be blamed (or praised) for what they do; second, that insofar as men are human beings not machines they always have some choice in how they act—hence they are *always* responsible for this conduct. There is method in madness, no less than sanity. [1972b:135]

Thus both Laing and Szasz, though they represent diametrically opposed political traditions, arrive at an anti-psychiatric critique that "normalizes" behavior that others have diagnosed as abnormal.

Though the range of proscribed behaviors included among the "victimless crimes" varies among conceptualizations, most include public drunkenness, drug use, gambling, and sexual behavior between consenting adults. (Schur, 1965; Kadish, 1968; Smith and Pollack, 1971; Castelli, 1972). Common to all is that any harm done is committed by the actor either against himself, to him with his own consent, or against a consenting partner. Thus in a conventional sense there exists no victim seeking redress or protection from a public authority. Indeed it is the public authority which is offended against and which must *seek out* the transgressor. It is this which has led Edwin Schur to argue that the effort to enforce such norms involves an effort to "legislate morality for its own sake" (1965).

Of primary concern to those who have written about victimless crimes has been the inefficacy of the criminal sanction in controlling immoral behavior[30] as well as the unintended and untoward consequences that such efforts have had for the functioning of the criminal justice system (Skolnick, 1966). In the

30. Herbert Packer (1968:365), the late legal theoretician, wrote:
> The criminal sanction is the best available device we have for dealing with gross immediate harm. It becomes less useful as the harm becomes less gross or immediate. It becomes largely ineffective when it is used to enforce morality rather than to deal with conduct that is generally seen as harmful.

distinction between morality and harmful conduct we can hear a strong echo of the Hart-Devlin debates, with adherents of the victimless crime position asserting the need to separate society's legitimate concern for the protection of its citizens from the illegitimate desire to impose moral rectitude. As Morris and Hawkins have stated in their popular *The Honest Politician's Guide to Crime Control*:

> For the criminal law at least man has an inalienable right to go to hell in his own fashion provided he does not directly injure the person or property of another on the way. The criminal law is an inefficient instrument for imposing the good life on others. [1970:2]

In all its forms the ideology of tolerance has tended to stress the willful choice of those who have acted in socially disapproved ways. In some instances that choice has been romanticized as a rejection of a corrupt social system. In others it has been regretted as a foolish personal indulgence. Such behavior is seen as posing no threat to the order of things; problems arise primarily because of the efforts of those with legal, social, and medical power to require behavioral comformity.

Older models of social control had assumed such volition as the basis for applying, or threatening to apply, the criminal sanction.[31] The deterministic formulations derived from psychological and sociological orientations towards human action minimized the volitional element in behavior.[32] The ideology of tolerance restores volition to a central position as a way of advocating acceptance for "human diversity." Since diversity is thus perceived as an outgrowth of human choice, tolerance is presented as an expansion of the realm of freedom.

In the justification for punishment, the social setting of human behavior, as well as the extent to which that context unevenly

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31. Leon Radzinowicz (1966:12-13) has stated with regard to the liberal conceptualization of the criminal law:

> Outside the narrow and rigidly defined categories recognized by law it took little if any account of the possibility that crime might be socially and individually conditioned, . . . The potential offender was seen as an independent, reasoning individual weighing up the consequences of crime and deciding the balance of advantage. He was assumed to have the same powers of resistance as other individuals, to deserve the same punishment for the same crime, and to react in the same way to the same punishment.

The classical statement of this position, of course, is to be found in Cesare Beccaria (1975).

32. Marvin Wolfgang has said:

> However firmly free-will philosophy may have been rooted in criminal law and classical criminology, positivism from France and Italy, social Darwinsim from England, the dialectics of materialism from Germany and other philosophic forces have so uprooted the plant that today even the slowly moving traditions of legal thought are [affected] by determinism as a framework for action and improvement. [Wolfgang, 1968:66-67]

For a discussion of the rise of deterministic criminology see Kittrie (1973).

affects different classes, is largely ignored in order to permit the ascription of guilt to the individual transgressor.[33] Although some deterministic ideologies attribute controlling force to intrapsychic mechanisms, many acknowledge that the wider social environment significantly influences which classes of persons tend to violate social proscriptions. The latter determinism, which contains the element of a social critique, may serve to justify the preventive apprehension of individuals who, it is assumed, cannot control their own behavior.[34] By focusing on the autonomy of the individual actor the ideology of tolerance, like the ideological defense of punishment, tends to perceive human behavior in abstract terms largely removed from the context of social misery.

There is here a great irony. The ideology of tolerance, presented as a critical force in the service of freeing those caught in the web of contemporary social control, actually tends to serve a profoundly repressive function. The process by which tolerance "turns into its opposite" has been analyzed by Herbert Marcuse, who has noted:

> When tolerance mainly serves the protection and preservation of a repressive society, when it serves to neutralize opposition and to render men immune against other and better forms of life, then tolerance has been perverted. [1965:111]

Though Marcuse's analysis is primarily concerned with the extent to which tolerance is *demanded by those in power* for policies that "are impeding if not destroying the chances of creating an existence without fear and misery" (1965:82) it is possible to extend his insights to the ideology of tolerance that purports to express the *desires of those who have been subject to the intolerance of those in power*.

When the ideology of tolerance criticizes the institutional oppression of the law, the hospital, and the asylum by asserting the "right" to "go to hell" in one's own way, it retains the concepts of freedom and choice while "turning them into their opposites." Instead of assisting in the struggle against human misery those concepts provide the justification for choosing human misery. Because the ideology of tolerance tends to conceal the extent to which certain forms of deviance are reactions to deprivations rooted in the social order—indeed, can be considered as determined by that order—and because it seeks to integrate behavior that should serve as the starting point for a critique of society, it serves to neutralize the possibility of opposition.

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33. It is that which led Justice Bazelon to declare in his Isaac Ray award lecture: "One cannot too often repeat that the greatest inequality is equal treatment of unequals" (1961:8). That is a restatement of Anatole France's barb regarding the "majestic equality of the law which forbids the rich as well as the poor to sleep under the bridges, to beg in the streets, and to steal bread."
34. The deterministic position in the criminal sphere called for a system of "criminal prophylaxis" (Radzinowicz, 1966:55).

In addition to its impact on the manner in which the nature of human deviance is understood and perceived, the ideology of tolerance may, by providing the justification for actual social policies and practices, foster behavior that undercuts the possibility of a successful challenge to the prevailing social order. Marcuse calls such tolerance "repressive desublimation."

> The publicity of self-actualization . . . promotes existence in that immediacy which in a repressive society is (to use . . . an Hegelian term) bad immediacy (*Schlechte Unmittelbarkeit*). It isolates the individual from the one dimension where he could "find himself" from his political existence, which is at the core of his entire existence. Instead it encourages non-conformity and letting-go in ways which leave the real engines of repression in the society intact, which even strengthen those engines by substituting the satisfactions of private and personal rebellion for a more than private and personal, and therefore more authentic, opposition. The desublimation involved in this sort of self actualization is itself repressive. [1965:114-115]

The point here is not to minimize the extent to which intolerance or suppression of certain forms of behavior causes suffering to those who desire to act in proscribed ways, but rather to underscore the extent to which, in a repressive society, partial reforms that advance the possibility of apparently less restrictive behavioral codes become integrated into the social totality, become functional to its continued existence, and hence themselves become repressive.

It is in the context of this analysis that we can seek to develop a critical perspective toward the movement for heroin decriminalization. To the extent that such proposals see heroin use as a free choice and either minimize or suppress from view the degree to which involvement with narcotics reflects the profound inequality that characterizes the American social structure they serve to protect the prevailing order from criticism. To the extent that such proposals would advance the integration of narcotics-using behavior into the social totality they would provide yet another mechanism for blunting the disaffection of the underclass.

Those who advocate dismantling the apparatus of state control over narcotics assert that their proposals are inspired by humane considerations. Whether timidly suggesting that possession related offenses be eliminated or radically proposing the free sale of heroin in "liquor stores," the advocates of decriminalization seek to lift the burden of state repression from those who wish to use narcotics. Although the success of their efforts would in fact lift that burden, it is argued here that the full meaning of heroin decriminalization is not to be found in the proclamations of the

reformers but in the social functions of drug use in the United States.[35]

35. For a very suggestive analysis of the manner in which a drug prohibited in the United States is used in, indeed integrated into, the life and culture of another society see the discussion of the chewing of the coca leaf by Indians in Peru in Grinspoon and Bakalar (1976). Of special importance is the balanced description of the function of coca in suppressing hunger and in making hard work bearable under conditions of considerable economic privation.

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