

Involuntary Treatment of Drug Addiction

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Controversy surrounding the complex issues involved in the compulsory treatment of addicts is by no means new. Statutes explicitly substituting compulsory "treatment" for criminal penalties in the case of addicts charged with criminal offenses, and providing for the involuntary commitment of addicts upon civil complaint, first appeared in 1961 in California, and then in New York, Massachusetts, and Maryland, as well as on the Federal level.¹ But given society's present concern with the "drug problem," it is inevitable that, as the waiting lists of applicants for voluntary treatment programs are eliminated by the expansion of these latter programs, the debate over involuntary treatment will grow.

The premise underlying the position that addicts should be forced to undergo treatment for their own good is that they are sick and thus in need of the treatment which we wish to impose against their will. Yet no physical ailment is universally found among narcotics addicts. The conditions under which addicts on the street are forced, under present law, to secure and administer opiates substantially increases their chances of contracting hepatitis and a variety of bacterial infections. But it has long been known that no physical deterioration results from the prolonged use, in itself, of opiates.² Since there is no universally identifiable physical ailment present among addicts, the illness we purport to "cure" must be mental, and addicts (like all mental patients) are essentially powerless to refute the diagnosis. In fact, protestations are considered further confirmation of both the psychopathology which is said to exist, and its severity, since it is a well known adage that inability to recognize and accept one's own illness proves just how sick one really is!

The process of labelling addicts mentally sick, and the conclusion drawn from this generalization, is summed up as follows:

In recent years, professionals, nonprofessionals, and groups best designated unprofessionals, have taken to viewing drug abuse as a symptom of psychopathology necessitating verbal and/or chemotherapeutic intervention. . . . The main point is that once we view the drug abuser as being sick, we automatically fall into the trap of assuming and recommending 'treatment' for him. The choice between traditional and avant garde modalities is but a minor one once our initial perception is set of the person and his 'problem.'³

1 Cal. Welfare and Institutions Code § 3050-3054, 3100-3111. (West) N.Y. Mental Hygiene Law § 81.13, 81.21, 81.23 (McKinney) Md. Ann. Code Article 43B, § 9, 12. 18 U.S.C. § 4251-4255, 42 U.S.C. § 3411-3426. The Massachusetts involuntary commitment program, Mass. Ann. Laws ch. 111A, § 1-10, was repealed in 1969.

2 E. Brecher *et al.*, *Licit and Illicit Drugs* (1972), at 21-32.

3 S. Einstein and W. Garitano, *Treating the Drug Abuser: problems, factors, and alternatives*, 7 *The International Journal of the Addictions* 324, no. 2 (1972).

Generalizations applied to addicts are immediately suspect, since the addicted universe itself is so ill-defined. People are deemed addicts on the basis of laboratory tests which give an indication only of recent (as opposed to habitual) drug use. This "objective" measure is then supported by medical examination, which is generally cursory and inconclusive, and by a past social-medical history which is notoriously unreliable, especially when the patient-practitioner relationship is not voluntary.

Nevertheless, physicians who accept the notion that all addicts are psychologically ill are at no loss for specific diagnoses of individual patients. One study of 91 women addicts, for instance, reported every single subject to be suffering from either brain syndrome, psychotic disorder, psychoneurotic disorder, personality pattern disorder, personality trait disorder or sociopathic personality disorder.⁴

Empirical evidence, however, such as the well-documented success of methadone maintenance treatment of heroin addicts⁵, refutes the contention that addiction must be associated with some form of psychopathology. Most methadone maintenance programs, in assisting a large proportion of their voluntary patients to return to a productive role in society, supplement the medication itself with pragmatic counseling aimed at *external* problems such as housing, employment, legal cases, etc., rather than with psychotherapy.⁶

Nevertheless, there is considerable appeal in attributing the growing use of illicit drugs to psychological illness of the addicts themselves. Indeed, "blaming the victim"⁷ is a traditional response to social ills (the classic example of this approach is the conclusion that malnutrition among the poor is due to the fact that "... low income families place less value on food than we think.")⁸ Political realities explain the attractiveness of seeking both the cause and the cure for addiction within the addict himself. As difficult as may be the task of rounding up drug addicts against whom one imposes nominally therapeutic measures, it is far easier than attempting to change the socio-economic and other external factors which play a role. Compulsory treatment, by focusing on real or imagined short-comings within the addict, serves to draw attention away from these environmental problems, and the result must inevitably be counter-productive.

"I'll make him an offer
he can't refuse."⁹

The "diversion" of addicts from the criminal justice system to a treatment setting, purporting to deal with addict-offenders as "patients" rather than as criminals, has been heralded as an enlightened, humane alternative to an expensive and ineffective prison stay. There are several mechanisms by which the criminal justice system forces addicts into treatment. In many situations the court, upon conviction of an addict, may *impose a sentence* which specifically mandates a term in a treatment facility in lieu of prison. Such terms can extend either for an indefinite period of time, depending upon the "progress" perceived by the clinician, or for a minimum duration which frequently exceeds the longest sentence possible for the criminal act itself.¹⁰

The other common diversion technique offers a "choice" to the addict: either stay in prison, or "voluntarily" request release which will be conditioned upon entering and remaining in a specified treatment program. This practice is particularly invidious when it is applied (as is increasingly the case) to the pre-trial addict-prisoner whose alleged offense is compounded by his inability to obtain bail money. Frequently, the prosecutor's agreement to the release of defendants is reserved for those persons whose charges are relatively minor (i.e., misdemeanor and low-degree, drug-related felonies).

Those involved, therefore, are primarily poor people, arrested on charges of which they are presumed innocent under the law, and which, even upon conviction, would carry comparatively short sentences. They are "offered the opportunity" to enter a treatment program they may or may not want or need, and which will in any event provide society with the means of observing and controlling their activities for an extended period of time. Such coercion of legally innocent detainees is possible since overcrowded court calendars and other delays inherent in the judicial process make virtually any alternative more attractive than continued incarceration while awaiting trial. Incredibly, it is in precisely these cases that advocates embrace diversion as an especially humane and appropriate expedient.

4 C. Chambers, R. N. Hinesley, and M. Moldestad, *Narcotic Addiction in Females*, 5 *The International Journal of the Addictions* 274, no. 2 (1970).

5 F. Gearing, in *Proceedings of the Fourth National Conference on Methadone Treatment*, NAPAN, at 157 (1972).

6 H. Joseph and V. Dole, *Methadone Patients on Probation and Parole*, 34 *Federal Probation* 42, and 44, no. 2 (June, 1970).

7 W. Ryan, *Blaming the Victim* (1972).

8 U.S. Department of Agriculture, quoted by E. Drew in *Going Hungry in America: government's failure*, *The Atlantic Monthly* 53, at 55 (December, 1968).

9 Don Corleone in Mario Puzo, *The Godfather*, 39 (1969).

10 J. DeLong, *Treatment and Rehabilitation*, in *Dealing with Drug Abuse—A Report to the Ford Foundation*, 186 (1972).

Those who work in the criminal justice system are inevitably plagued by the knowledge that while prisons do not as a rule "correct" anybody, simply releasing convicted criminals without punishment is not feasible. The tempting middle road with addict-defendants is to force them, under *threat* of imprisonment, to enter a treatment facility with the assurance that the clinical staff will promptly report abscondence or continued involvement in "anti-social" activities.

The attractiveness of such an approach is that it seems to offer something to everyone: the problem of ineffective and overcrowded jails is addressed; the judge is reasonably secure in the belief that the treatment facility staff will closely monitor the addict's behavior; the addict has been permitted to escape prison confinement, at least temporarily, for a more subtle (though perhaps longer) punishment; and finally, the treatment center frequently welcomes the added "business" and often believes that it will be more successful in dealing with what amounts to a captive population.

In fact, this type of program is a perversion of the role of all the parties concerned. The *judge* engages in inequitable justice by providing different punishment to different people convicted of the same offense, merely because one happens to be an addict and is deemed "treatable" and the other is not. Also, the judge imposes as the primary criterion of continued release attendance at a facility which may or may not offer society (let alone the addict) any benefits. The basic premise underlying such conditional release is that there is an inherent value in being in a treatment program this assumption is as invalid as the belief that there is an inherent virtue in being a member of a particular religion, or political party, or any other group. Finally the judge is left with the task of deciding which type of treatment program should be required, a clinical decision for which he is usually totally unqualified, and which will depend more on personal bias than on objective determination.

The clinical staff, in agreeing to share the responsibilities of the criminal justice system, can not meet its primary obligation to the patient. It thereby severely compromises its ability to serve *either* patients *or* the community. Clinical judgment is also compromised, since *medical* decisions (to terminate treatment, for instance) can and generally do lead to inevitable *criminal* sanctions against the client.

The addict-defendant, who has not yet been tried or convicted, forfeits the opportunity to prove his innocence by accepting treatment in lieu of prosecution and the attendant pre-trial incarceration. Moreover, the addict, forced to accept "treatment" which he generally does not want for an "illness" which he more often than not believes is non-existent, is not impressed with the argument that he is being deprived of his liberty for his own good. He generally perceives "treatment" as simply another form of punishment, if indeed he sees any difference from a criminal sentence whatever. Proponents of compulsory treatment acknowledge this, and cite it as an argument *for*, rather than against, depriving the addict of a choice. The addict's perception that he is being punished, rather than helped, seems to be shared by the lay press, as evidenced by phraseology such as the following:

4 Escape Yonkers Narco Center

Police yesterday were seeking four inmates who escaped Sunday night from the . . . Rehabilitation Center in Yonkers. . . . A fifth was captured by a guard at the Center shortly after the break. ¹¹ (emphasis added) In the Therapeutic State toward which we appear to be moving, the principle requisite for the role of Big Brother may be an MD degree. ¹²

The causes of drug addiction are as complex as society itself, and they must be faced directly. The analogy is frequently made between drug addiction and contagious disease. In that context, it should be noted that even where a readily defined illness exists (which is not the case with addiction), and even where the illness can be effectively cured by appropriate treatment (which also is not the case with addiction), elimination of the problem from a community generally requires far broader measures. Thus, tuberculosis was brought under control not by the introduction of chemotherapeutic agents, but by a substantial improvement in living conditions; in areas where that improvement has not occurred, the disease persists despite the medication which is available. Venereal disease is also widespread throughout the world, even though each individual patient can be readily diagnosed and cured. Similarly, we must recognize that addiction is a social problem which will never be eliminated by measures that are imposed on the addicts themselves, and until this is understood our effectiveness in dealing with drug abuse will remain severely limited.

The nature of the therapeutic relation between doctor and patient is greatly affected, needless to say, by the manner in which the patient comes to be the recipient of treatment. The voluntary character of that relationship is by no means precluded by the existence of outside pressures on the patient. Rather the word "voluntary" ". . . implies the exercise of one's free choice or will . . . whether or not external influences are at work."¹³ (emphasis added) The difficulty, of course, is determining what constitutes "free choice." However unappealing the alternative presented, the addict nevertheless always retains the option of choosing the sanction associated with *not* entering a treatment program. One could thus argue that there are only voluntary patients and those others punished for failing to volunteer, but no involuntary patients. Such an argument, however, ignores the loss of freedom we feel when coerced into choosing between two disagreeable courses of action. To avoid this sterile conclusion it is necessary to define voluntarism pragmatically in terms of the relationship which exists between patient and practitioner.

In all treatment relations, society is an interested third party. But the extent to which society's interests intrude in the individual case is nonetheless crucial to the nature of the resultant therapeutic interaction. **Voluntary treatment describes a therapeutic relationship in which the primary responsibility of the clinician is to the patient. In an involuntary treatment setting the clinician's primary responsibility is to some third party.** An obligation, as in the statutory treatment schemes for addicts, to report patient attendance, progress or termination to an outside individual or agency defines the relationship as involuntary, even if patients are induced to sign, in advance, open-ended authorizations for such reports.

The physical environment in which treatment is forced on people, whether behind bars, in a locked residential setting, or in a neighborhood store-front serving ambulatory patients, is to a large extent determined by the modality which is favored in a particular instance. But which mode of treatment is imposed in no way changes its involuntary character.

Legal experts may argue over the constitutionality of involuntary treatment of addicts. Politicians and the lay public may weigh the desirability and the dangers of such treatment. Economists may enter into heated debates over its absolute and relative cost-effectiveness. **But the clinician who accepts patients rendered powerless to refuse his services by legislative fiat (as opposed to medical incapacity), must be viewed in the role of persecutor.** Rationalizations should not obscure the issue: in dealing with an unwilling subject, a doctor is by definition striving to bring about a change which the patient does not wish, but which the government has mandated. He accepts payment from society in order to work against the perceived self-interest expressed by the patient; in such instances, the concepts of treatment and cure lose all meaning.

There are legal restraints against an internist who, in his professional wisdom, may be tempted to imprison a diabetic who fails to adhere to a prescribed diet. A surgeon, recognizing the inevitable consequences of ignoring a malignancy, is nevertheless restrained by professional as well as legal sanctions from operating on a cancer patient without informed consent. The seemingly self-evident nature of these examples would indicate that the medical profession has made considerable progress since the late 1930s, when a physician performed tubal ligation (sterilization) on 62 teen-age inmates of a Kansas reformatory as retribution for disorderly behavior.¹⁴

Any difference in the ethical repugnance of these real and hypothetical cases, and of the compulsory treatment of the illicit drug user, is in degree only. As Szasz (a psychiatrist) has pointed out, "Physicians who interfere with the medical patients' autonomy by treating them involuntarily are guilty of an offense, punishable by both civil and criminal statutes. Why should this not apply to similar offenses against mental patients?"¹⁵ Szasz does not condition his condemnation in any way on treatment outcome:

¹¹ New York Daily News, Sept. 7, 1971.

¹² T. Szasz, in *Medical Opinion and Review* 35 (May, 1968).

¹³ *Webster's New World Dictionary of the American Language* 1636, (1964).

¹⁴ Note, *What Has Happened to Kansas' Sterilization Laws?*, 2 *Kansas Law Review* 174, at 176-177 (1953-1954).

¹⁵ T. Szasz, *Law, Liberty and Psychiatry* 253 (1963).

**Success-
potentially more ominous
than failure**

Treating patients against their wishes, **even though the treatment may be medically correct**, should be considered an offense punishable by law. Let us not forget that every form of social oppression has, at some time during its history, been justified on the ground of helpfulness toward the oppressed.¹⁶ (emphasis added)

A keystone of the arguments favoring compulsory treatment is that meaningful therapy can be and is provided. In the words of a presidential Commission on Law Enforcement and the Administration of Justice, It is essential that the commitment laws be construed and executed to serve the purpose for which they were intended and by which alone they can be justified. This purpose is treatment in fact and not merely confinement with the pretense of treatment.¹⁷

Moreover, to the extent that the treatment offered is ineffective,¹⁸ serious doubts are raised concerning the constitutionality of the use of civil commitment procedures by the statutory addict commitment programs. A 1969 decision of the New York Court of Appeals pointed out that:

The extended period of deprivation of liberty which the statute [New York States's Narcotic Control Act] mandates can only be justified as necessary to fulfill the purpose of the program.¹⁹

It went on to say that:

... If compulsory commitment turns out in fact to be a veneer for an extended jail term and is not a fully developed, comprehensive **and effective** scheme, it will have lost its claim to be a project devoted solely to curative ends.

... The moment the program begins to serve the traditional purposes of criminal punishment, such as deterrence, preventive detention, or retribution, then the extended denial of liberty is simply no different from a prison sentence, and the constitutional guarantees applicable to criminal proceedings will apply in full measure.²⁰ (emphasis added)

Whether the key criterion of effectiveness is in fact met is highly questionable. Reports on the results of involuntary treatment have been consistent in the grim picture they present of extremely high recidivism rates.²¹ Furthermore, in practice, this critical demonstration that compulsory programs are "fully developed, comprehensive and effective" is left to those responsible for the programs' operations. This is a weak foundation indeed upon which to permit and encourage the deprivation of liberties of tens of thousands of citizens.

But to focus attention on the failure, in its own terms, of the treatment rationale for the incarceration of addicts ignores the fact that effectiveness, or "success," is a potentially far worse consequence for the unwilling subject. By definition, the involuntary patient enters the enforced therapeutic relationship rejecting that which the clinician sees as the desirable objective. Cure and rehabilitation therefore become synonymous with achieving that which the addict does not want, and this can be accomplished only by changing values and attitudes along with behavior. The all-powerful clinical director, acting for society, is the sole judge of what is healthy and appropriate.

The following excerpt from a military medical journal is an example of psychiatrically defined success which in medical terminology could be classified as iatrogenic psychosis (in plain language, medical intervention which has destroyed an individual's ability to perceive and appropriately respond to reality):

... Fear of Flying: A 26 year old Sgt. AC 47 gunner with 7 months active duty in RVN, presented with frank admission of fear of flying. He had flown over 100 missions, and loss of several aircraft and loss of several crews who were well known to the patient, precipitated his visit. He stated he would give up flight pay, promotion, medals, etc., just to stop flying. Psychiatric consultation to USAF Hospital, Cam Ranh Bay, resulted in 36 days hospitalization with use of psychotherapy and tranquilizers. Diagnosis was Gross Stress Reaction, manifest by anxiety, tenseness, a fear of death expressed in the form of rationalizations and inability to function. His problem was worked through and insight to his problem was gained to the extent that he was returned to full flying duty in less than 6 weeks. This is a fine tribute to the psychiatrists at Cam Ranh Bay (633 Combat Spt. Gp. Dispensary, Pleiku AB).²²

It is unclear from this case history whether the sergeant was a voluntary or involuntary patient, though it would appear that he presented his superiors (and the doctors) with a firm decision to stop flying rather than with a symptom of illness for which he sought help. The conflicts inherent in attempting to modify behavior, however, are *always* present when practitioners relate to addicts compelled to accept their services: the clinician defines the disease and makes the diagnosis; the clinician decides on the therapeutic goals and implements the procedures he hopes will achieve these goals, though they are openly rejected by the patient; and, finally, the clinician measures the effectiveness of treatment. Should he decide that the therapy is not sufficiently successful, it is the patient who pays the price of continued, unwanted treatment.

It is naive to assume that the power which is given the practitioner over the involuntary patient will not be applied to its fullest degree. The following candid statement outlines what society expects its agents—the clinicians—to accomplish:

From the addict's point of view, he properly perceives that the therapist is, in fact, trying to engage him in a conventional life, which will often mean low pay and prestige, continued insecurity, and poor access to the goals of our affluent society. This conformity, **which society demands of the addict**, is neither respected nor valued when it is achieved.²³ (emphasis added)

Like the Air Force sergeant who, understandably, did not want to fly again but returned to flying duty after "treatment," these patients are considered "successful" when they are willing to accept whatever grim reality is considered by others to be appropriate.

Drug abuse, *per se*, is the activity which, once labelled an illness, forms the spurious medico-legal rationale for permitting unwanted treatment to be forced on the addict. The objectives of the "rehabilitation" process, however, will almost invariably be far broader than simply eliminating the illicit use of drugs. All other forms of behavior which the clinician believes, on the basis of his own and society's prejudices, to be pathological will also be dealt with.

16 *Id.*, 185, 253.

17 President's Commission on Law Enforcement and the Administration of Justice, *Task Force Report: Narcotics and Drug Abuse* 16 (1967).

18 E. Brecher, *supra*, note 2, 64-89.

19 *People v. Fuller*, 24 N.Y. 2d 292, at 301 (1969).

20 *Id.*, at 302, 303.

21 See note 18, *supra*.

22 11 PACAF Medical Journal 5, no. 8 (July, 1967).

23 B. Brill and L. Lieberman, *Authority and Addiction*, 57 (1969).

Thus the addict who is a homosexual may well find his sexual preference a focus of the therapist, while the non-addict homosexual (despite the acknowledged burdens which society imposes) can not be deprived of his liberty or forced into undergoing therapy in most states. The same is true of the involuntarily committed addict who belongs to a bizarre religious sect; or who is a member of a radical political group; or who engages in any other activity which does not have the blessings of the general population and is thus classified as "deviant" and an additional component of the "symptom" complex. Some proponents of compulsory treatment define the broad nature of their goals quite explicitly:

To alter, where indicated, the attitudes and behaviors of the addict in the areas of:

- a work
- b friendship and heterosexual relationships
- c family responsibility
- d leisure time activities
- e criminality.²⁴

It goes without saying that the *clinician* decides when changes are "indicated," and the involuntary patient is compelled to acquiesce, as a prerequisite to discharge.

Consequences of Abandoning Involuntary Treatment

It would be wrong to assume that arguments against involuntary treatment in any way denigrate the value and importance of *voluntary* services. Although a law mandating treatment of everyone over a specified weight would be unthinkable, people who are obese should have access to medical assistance for weight reduction if they want it.

Moreover, the continued counter-productive and inhumane imprisonment of addicts is not an inevitable consequence of eliminating coercive referrals for treatment. The number and type of people incarcerated is a reflection of the orientation and emphasis of enforcement agencies, prosecutors and the judiciary. Rounding up drug users and imposing long jail terms for charges of possession of "dangerous drugs" is admittedly no more rational or productive than sentencing such people to therapy. The continuation of such practices is simply the realization in concrete terms of the inconsistencies in the thinking of the Supreme Court in the well-known case of *Robinson v. California*: while ruling that the application of criminal penalties to the status of addiction *per se* violated the constitutional ban on cruel and unusual punishment, the Court nonetheless simultaneously and explicitly approved criminal penalties for the use and possession of drugs that addiction entails.²⁵

It should also be emphasized that the arguments against the compulsory treatment of addicts in no way lessen the desirability of the retention of alternatives in the criminal justice system to incarceration, such as parole and probation. Rather, they are directed only against the *use of parole and probation to coerce people into accepting therapy*.

If compulsory treatment as a form of punishment is to be eliminated, this would simultaneously preclude the addict-defendant from pleading illness as a justification for crime, or as a rationale for avoiding the usual penalties which the court imposes on non-addicts for similar offenses. Equal *severity* of the law is no less a principle than the corollary equal *protection*. The proposition that incarceration of convicted criminals serves no useful purpose may well be correct; whatever alternatives are suggested, however, should not distinguish between people on the basis of drug abuse.

Finally, in contemplating the impact of eliminating involuntary treatment of addicts, it is well to consider the insignificant role involuntary treatment plays in two countries where addiction seems to have been contained, England and Japan.

English laws, though reputedly dealing with addiction as a medical rather than criminal problem, do not actually compel anyone to enter treatment. Nor is the addict offered a "choice" of therapy in lieu of pre-trial detention, or as a condition of release from jail after conviction. Thus, eliminating criminal sanctions for the state of addiction and the associated possession and use of addicting drugs does not require a concomitant policy of forcing drug abusers into treatment.

In the case of Japan, the 1963 Narcotics Control Law did provide for compulsory hospitalization. At the same time, however, this statute heralded a massive enforcement effort against narcotics importation and trafficking, launched by a police department with a reputation for absolute incorruptibility. These factors and others in the ensuing six years resulted in a decline in the estimated number of heroin addicts from 40,000 to a few hundred.²⁶ The role of involuntary hospitalization in this achievement was insignificant during the six year period only 593 people were forced to accept treatment, and it is relevant to note that in Japan treatment of addicts is *never* a substitute for prosecution or incarceration.²⁷

The principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose 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 can not rightfully be compelled to do or forbear because it will be wise, or even right. These are good reasons for remonstrating with him or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with an evil in case he do otherwise.²⁸

Whatever the terminology used and whatever the means by which coercion is applied, compulsory treatment of addicts is void of benefits and counter-productive of the goals which form the rationale for depriving people of their liberty. The interests of society can not possibly be protected by ineffective attempts to force attitudinal and behavioral change on resentful and unwilling subjects; the rights of all Americans are severely threatened when the principle is established of ignoring safeguards of our criminal justice system. The assertion that compulsory treatment is in the interests of those who are forced into therapy is equally spurious; such efforts have been proven a costly, unsuccessful error in the past, and they are doomed to fail in the future.

There is little doubt that proposals such as the following will become more common as the addiction problem remains unsolved:

A prominent New York City politician has called for a crack-down on violent crime by interning hard-core narcotics addicts in treatment camps . . . 'if that's what they need.'²⁹

Concern over such proposed "solutions," which are as inevitably self-defeating as they are radical, should not obscure the fact that the more subtle forms of compulsory treatment are an even greater danger.

²⁴ *Id.*, 112.

²⁵ *Robinson v. California*, 370 U.S. 660, at 664 (1962).

²⁶ Japan Ministry of Health and Welfare, *A Brief Account of Narcotics Abuse and Countermeasures in Japan*, 7 (1970).

²⁷ *Id.*, 9.

²⁸ J. Mill, *On Liberty, and Other Essays* 13 (1926).

²⁹ S. Leone, quoted in *N.Y. Times*, Dec. 12, 1971.