Legal Cocaine and Kids: The Very Bitterness of Shame

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I have prayed with drops of agony on my Brow, trembling not only before the Justice of my Maker, but even before the Mercy of my Redeemer. "I gave thee so many Talents. What hast thou done with them?" [N]ot only to friends have I stated the whole Case with tears & the very bitterness of shame; but in two instances I have warned young men, mere acquaintances who had spoken of having taken Laudanum, of the direful Consequences, by an ample exposition of its tremendous effects on myself . . . .

—Samuel Taylor Coleridge

The beautiful wreckage of Coleridge’s opium-scarred life carried as its cargo many of the dreams, and most of the nightmares, that would come to define the modern era. His restless nights were filled with a “fiendish crowd of shapes and thoughts” that left him “in anguish and in agony.”*2 Thinking opium (laudanum) to be a harmless painkiller, he innocently acquired an addiction to it in his youth. Cursed with what later moderns would consider a “disease,”

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he found his deeply traditional nature locked in hopeless battle with what it could only conceive of as a sin. He appears all the more unwillingly modern in finding that his prayers to be relieved of addiction went unanswered and that his warnings to the young sounded in vain.3

Cocaine has been the laudanum of the twentieth century, trumpeted as a relatively safe drug even as it was beginning to savage hundreds of thousands of young lives.4 Coca (from which cocaine is derived) was praised by doctors in the 1880’s as a cure for opium addiction.5 As late as 1980, physicians were still describing cocaine as non-addictive.6 We know now how mistaken these views were,7 but this knowledge does not, by itself, dictate our appropriate course. Attacking cocaine as sinful and warning the young against its use do not seem sufficient responses, and not just because our sense of sin has weakened and our poets have lost much of their influence.

Eighty-eight percent of Americans believe cocaine trafficking should be a crime,8 as it is under federal law9 and the laws of every state.10 Yet, this is not the opinion of the majority of contributors to

3. See id. at 387, 394-95. Coleridge’s own Britain would, of course, in 1856 fight a war to force China to legalize opium. See A. BLOCK & W. CHAMBLISS, ORGANIZING CRIME 20-24 (1981) (analyzing the Opium War and stating that it was a triumph of mercantile capitalism).

4. For a searing description and analysis of the historical view that cocaine is relatively safe and nonaddicting, see Gawin & Ellinwood, Cocaine and Other Stimulants: Actions, Abuse, and Treatment, 318 NEW ENG. J. MED. 1173 (1988).


this symposium, nor is it in accord with the strongly held views of many influential commentators from both ends of the political spectrum.11 Sixty years ago the adherents of Prohibition swept the 1928 elections, winning some 80 percent of Congressional races;12 by the end of 1933 Prohibition was dead.13 Considering that one quarter of all young adults in this country have used cocaine,” opposition to its legalization may be far softer than polls reflect. Thus, the almost smug confidence of so many official proponents of a “war” on drugs

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Szasz asserts that individuals have a right to “eat, drink or inject a substance—any substance—not because we are sick and want it to cure us, nor because a government-supported medical authority claims that it will be good for us, but simply because we want to take it . . . .” T. Szasz, supra, at 271. Wisotsky, on the other hand, focuses on the futility of any war against cocaine. Wisotsky, supra, at 1424.


13. Prohibition ended with the ratification of the twenty-first amendment in December 1933. U.S. CONST. amend. XXI; see Aaron & Musto, supra note 12, at 173.

seems seriously misplaced, and the need to think carefully about the rationale for prohibition compelling.

The legal status of cocaine is important to the authors not as a matter of theory or politics, but for the survival of the homeless and runaway kids served in crisis programs such as the ones offered by Covenant House. Because of our work at Covenant House, we believed it was essential to participate in this symposium. From the outset, our perspective is an unusual one, largely bounded by our concern for marginal youth under the age of twenty-one, and most passionately directed at cocaine, which has severely damaged this group over the past several years. We do not approach drug legalization with expertise about the effects of cocaine on adults who consume it, but rather from terror over what legalized cocaine would do to kids.

Terror about legalized cocaine’s effect on the young is only one aspect of the larger public policy question toward substance abuse, but in our view it is a determinative one. Proponents of legalization have failed to explain the consequences of their position for the well-being of adolescents and children. In this Article, we attempt to face up to this question for the limited case of cocaine and its derivatives—especially “crack.”

Though hardly qualified to address the

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15. For a clear example of such overconfidence, see The White House Conference for a Drug Free America: Final Report 149-51 (1988), in which the argument against legalization receives a scant two and a half pages.

16. This Article refers to the adolescents and children who come to Covenant House and more generally to all children and youth under age 21, as “kids” despite our recognition that this term is often considered slang or even unprofessional. We do so because the alternatives seem to us worse. The word “children” suggests a population younger than the older adolescents, aged 18-20, who make up the majority of our clients, while the terms “youth” or “adolescents” appear to exclude the infants and young children whom we also serve and who constitute many of the most damaged victims of cocaine use among their elders on the street. See infra notes 26-181 and accompanying text. Of all common terms, “kid” alone denotes both a “young person” and a “child.” Webster’s New Collegiate Dictionary 628 (1980).

17. Covenant House is an independent not-for-profit agency that provides assistance to homeless youths through clinics and programs offered in New York, Toronto, Houston, Fort Lauderdale, New Orleans, Anchorage, and Los Angeles.

18. Thus, Grinspoon and Bakalar, who were cautious advocates for decriminalization and wrote that cocaine “is not a serious social problem and... may be doing as much good as harm,” have failed in their lengthy analysis of drug policy to consider what effects legalization might have on adolescents. These authors also neglected to discuss special policies directed at protecting the young. See L. Grinspoon & J. Bakalar, supra note 5, at 236. But see supra note 6 and accompanying text (noting that Grinspoon and Bakalar have recanted prior views dismissing the dangers of cocaine use).

19. “Crack,” also known as “freebase” is the street name for smokeable cocaine, which is manufactured from cocaine hydrochloride. R. Siegel, Cocaine Smoking: Nature and Extent of Coca Paste and Cocaine Free-Base Abuse, in Cocaine: A Clinician’s Handbook 175, at
full sweep of future drug policy, we hope to offer the beginnings of a disciplined approach to this part of it.

Consistent with the Franciscan philosophic tradition that underlies the work of Covenant House, and in line with our caution in entering into so complex a debate, we have attempted to find our way toward general truths by paying close attention to specifics. This Article first describes our own struggles with the ravages of cocaine among the kids who seek crisis shelter and services at Covenant House and then briefly examines other evidence bearing directly on cocaine abuse among street kids. Second, it examines the extent of cocaine use among American adolescents, suggested causes for such use, and its effects. Third, it analyzes various means of protecting adolescents and children from the damaging presence of cocaine in society, including criminal prohibitions, prevention efforts, and treatment. This Article concludes with a brief inquiry into the possible effects of legalization on the social contract to provide government support for the poor and disabled that was forged in this country in the New Deal, and with some suggested common ground between opponents and advocates of legalization.

I. COCAINE AND STREET KIDS

With respect to cocaine, Covenant House felt the dragon’s breath late but hot. Covenant House is accustomed to serving the


20. The Franciscan scholastic tradition is rooted deeply in John Duns Scotus’s “desire to guarantee as completely as possible the originality of the individual,” a desire that led him to a philosophy that “restricts the form of a species to the singularity of its individuals.” E. Gilson, *History of Christian Philosophy in the Middle Ages* 462-63 (1955). It is a philosophy that emphasizes the “primacy of nobility of the will over the intellect in man” and “announces a more voluntarist than intellectualist conception of liberty”. Id. at 463. This is concededly not a tradition given to abstract categories of human liberty, which may explain in part our differences in this quite non-medieval context from those who view cocaine policy via a pure “rights” analysis.

21. See infra notes 26-33 and accompanying text.
22. See infra notes 34-63 and accompanying text.
23. See infra notes 64-183 and accompanying text.
24. See infra notes 184-224 and accompanying text.
25. See infra notes 225-37 and accompanying text.
most wounded and difficult of adolescents since it provides crisis and long-term shelter, and services to over 25,000 homeless and runaway kids annually. In the seven North American cities where Covenant House currently operates shelter programs,27 61% of our clients are male, 54% are aged eighteen to twenty, and 62% are black, hispanic or Native American. Their families are rarely intact and only a small minority can realistically return home. Indeed, many have long histories in foster care. In addition to shelter, our services include medical and legal assistance, counseling, vocational and educational programs, substance abuse treatment and aftercare. From July, 1988 to July, 1989, Covenant House provided crisis care to 1,096 infants and toddlers in the company of their adolescent mothers and to hundreds of pregnant teenaged girls.

This is a very troubled population. As late as 1984, drug use seemed to be less of a compelling issue compared with other problems afflicting these young people. In 1984, a study of runaway and homeless youth in New York City revealed that 82% were so depressed and disturbed by their condition that they could be considered to have a “significant psychiatric disability”28 and that three in ten had previously attempted suicide.29 Drug use was high when examined from an “ever used” perspective, but not especially surprising. The study revealed that 70% had at least once used marijuana, 33% hashish, 29% cocaine and 5% heroin.30 These rates were only marginally higher than “ever used” figures compiled from a national survey of high school seniors in the class of 1984.31 Likewise, the Covenant House staff was not stunned by a finding that 18% of the youths interviewed used alcohol to intoxication at least once a

27. Covenant House currently operates shelters in New York City, New York; Toronto, Canada; Houston, Texas; Fort Lauderdale, Florida; New Orleans, Louisiana; Anchorage, Alaska; and Los Angeles, California.
28. DIVISION OF CHILD PSYCHIATRY, NEW YORK STATE PSYCHIATRIC INST. AND COLUMBIA UNIV. COLLEGE OF PHYSICIANS & SURGEONS, RUNAWAY AND HOMELESS YOUTH IN NEW YORK CITY: A REPORT TO THE ITTLESON FOUNDATION 33 (1984) [hereinafter RUNAWAY AND HOMELESS YOUTH REPORT]. The vast majority of the youth participating in this study were residents of Covenant House; the remainder were interviewed in other New York runaway shelters. Id. at 18-23.
29. See id. at 35 (finding that 28 out of 117 youths had attempted suicide).
30. See id. at 38.
31. In the 1984 class, 55% had tried marijuana or hashish, 16% had tried cocaine, and 1.3% had tried heroin. NATIONAL INST. ON DRUG ABUSE, U.S. DEP’T OF HEALTH & HUMAN SERVS., DRUG USE, DRINKING, AND SMOKING: NATIONAL SURVEY RESULTS FROM HIGH SCHOOL, COLLEGE, AND YOUNG ADULT POPULATIONS 1975-1987, at 54 (1988) [hereinafter YOUTH DRUG SURVEY].
In response to the study's findings, Covenant House did not take immediate action to establish intensive substance-abuse prevention and treatment efforts. Instead, it directed its resources to improving mental health services and to establishing long-term transitional programs for kids who could not return home.

In taking a concerned but not alarmist view of substance abuse among its clients into the mid 1980's, Covenant House was more pessimistic than other runaway organizations. In 1980, a major study of runaways found that most social service and runaway agencies believed that the "typical" runaway did not abuse drugs or alcohol. In 1985, a major survey of over 200 runaway programs found that only 29% reported drug or alcohol abuse to be "major problems" affecting the youth in their programs. Drug abuse was typically regarded as simply a part of the street milieu that would end when youths received shelter and counseling. Cocaine was sold at too high a price for destitute kids on the street to regularly afford.

In only half a decade since these findings, we have all been chastened by a brutal epidemic of substance abuse that threatens to overcome all existing programs for homeless and runaway kids. The invention of "crack" in 1985 brought the street price of a powerful dose of cocaine down to $10 or less, well within the reach of street kids. As a result, abuse of cocaine has soared among Covenant

32. See Runaway and Homeless Youth Report, supra note 28, at 38. Nationally, 38.7% of the 1984 class reported having five or more drinks in a row in the last two weeks. Youth Drug Survey, supra note 31, at 57.
34. National Network of Runaway and Youth Servs., To Whom Do They Belong?: A Profile of America's Runaway and Homeless Youth and the Programs That Help Them 14 (1985).
35. See D. Miller, D. Miller, F. Hoffman & R. Duggan, supra note 33, at 115. "The majority of the agencies perceived the major problems of the runaway in terms of survival needs and consequently stressed program components, such as food, short-term shelter, counseling, and referral services to meet those needs." Id.
36. Grinspoon and Bakalar have noted, "[i]t is hardly easier to develop a damaging cocaine habit today than to become an alcoholic solely by drinking expensive brandy." L. Grinspoon & J. Bakalar, supra note 5, at 235.
In 1989, three youth surveys in Covenant House New York and one in Covenant House Florida indicated the extent of the change. A random survey of 155 files in the crisis shelter for March, 1989, revealed that 41% included references to serious drug abuse problems. A random study of fifty medical charts in our health services department several weeks later, showed that 60% of the youths had identified themselves as drug users. Thirty-four percent admitted using cocaine or crack, a figure almost certain to be well below true use levels. Another survey in the summer of 1989 evaluated fifty-two older youths who had visited the crisis shelter more than three times and were seeking readmittance. Fifty-eight percent of the youths admitted drug abuse. Fifteen percent admitted drug dealing and an additional 20% of the sample were suspected of dealing drugs.

Finally, this past summer, a study of 403 kids under twenty-one years of age at Covenant House Florida carefully accumulated data on the use of specific drugs. Preliminary results evidenced that almost one third (32.5%) of the youth have used cocaine, crack, or "crank" at least once—a rate close to, but higher than the 1984 New York figures. Even worse, seventy-nine youths (19%) had used some form of cocaine in the past thirty days, and forty (10%) reported current daily use. Most tragic of all, 34% of all girls who

40. J. Altman, M. Bresnahan & P. Pickens, supra note 38, at 3-4.
41. Id.
42. Denial of cocaine use in self-report interviews by young, low-income patients who tested positive in urine analysis, was found to represent 24% of all cocaine users in a large sample. Zuckerman, Frank, Hingson, Amaro, Levenson, Kayne, Parker, Vinci, Aboagye, Fried, Cabral, Timperi & Bauchner, Effects of Maternal Marijuana and Cocaine Use on Fetal Growth, 320 New Eng. J. Med. 762, 764 (1989). If that same rate of false denial applied to the Covenant House sample, the true rate of cocaine abuse would be slightly less than 50%.
43. Dodge, supra note 38, at 1.
44. Id. at 4.
45. Id.
46. J. Weatherhead, supra note 14, at 3-6.
47. Id. at 5. Crank is a smokable cocaine-heroin mixture. Id. at 3.
49. See J. Weatherhead, supra note 14, at 1.
are mothers or pregnant reported crack use in the past year, 23% in
the past thirty days.\textsuperscript{50}

This information must be read in context with other recent re-
search on homeless kids, especially two studies of street youth in Los
Angeles.\textsuperscript{51} The first compared runaway and homeless youth (aged
twelve to twenty-four) seeking services at two clinics with non-run-
aways coming to those same clinics.\textsuperscript{52} Use of stimulants, including
cocaine, was reported by 36% of the runaways but only 7% of non-
runaways; for intravenous drug, use the figures were 34% and 3% re-
spectively.\textsuperscript{53} A 1989 study of homeless youth under age eighteen in
Hollywood found that 39% of this younger sample met DSM-III
criteria\textsuperscript{54} for drug abuse and/or dependence,\textsuperscript{55} with over a quarter
reporting use of cocaine in the last thirty days,\textsuperscript{56} and \textit{half} admitted
to having sold illicit drugs.\textsuperscript{57}

The consequences of this increase in drug use—cocaine in par-
ticular—are only fully visible in the faces and bodies of kids who
seek crisis shelter from programs like Covenant House. Their furtive
expressions and emaciated frames cannot be captured in the lan-
guage or techniques of social science. Their wild-eyed eagerness to
leave “coke” and crack behind them, which often melts at the first
sign of difficulty, cannot easily penetrate academic discourse on indi-
vidual “choice” and “rights.” Almost certainly because of horren-
dous logistical obstacles, no study to date has successfully tracked a
group of street kids over a long-term period to examine the outcomes
of their experience. In most respects, therefore, we cannot say with
certainty what will become of street kids hooked on cocaine and
other drugs, except that their future seems far bleaker than those of
homeless but non-addicted youth.\textsuperscript{58}

\begin{footnotes}
\item[50] Id. at 3-4.
\item[51] See Alcohol Research Group, School of Public Health, Univ. of Cal., Berkeley,
Homeless Youth in Hollywood: Patterns of Alcohol Use: A Report to the Na-
tional Institute on Alcohol Abuse and Alcoholism (1989) [hereinafter Alco-
hol Research Group Study]; Yates, MacKenzie, Pennbridge & Cohen, A Risk Profile Com-
Risk Profile Study].
\item[52] See Risk Profile Study, supra note 51.
\item[53] Id. at 821.
\item[54] See generally Am. Psychiatric Assoc., Diagnostic And Statistical Manual Of
Mental Disorders (3d ed. 1987) [hereinafter DSM-III]. DSM-III is a manual that aids in
defining and classifying mental disorders.
\item[55] Alcohol Research Group Study, supra note 51, at 69.
\item[56] Id. at 67.
\item[57] Id. at 43.
\item[58] We assume, of course, that these kids are at least as vulnerable to all the normal
\end{footnotes}
What we can say with confidence is that many youth will die early from AIDS. In a recent study of 1,111 blood samples drawn from youth aged fifteen to twenty receiving health check-ups at Covenant House New York, 6.6% tested HIV positive. For youth over age twenty, the rate soared to 10.5%. To make matters worse, the apparently high “false-negative” rate under current testing methods suggests that the real infection rates in our population may be far higher. The authors of the study noted that drug use, particularly crack, is a key factor in HIV transmission among this population “because of the impetus it provides for prostitution and multiple sex partners.”

Crack often kills street kids violently when they try to survive by selling it. More often, however, crack kills silently through AIDS. Crack is also killing their spirits and smashing their fragile hopes for a better life. We do not pretend that their pain is a sufficient basis by itself to determine national cocaine policy, but we do urge that it not be ignored in the policy debate.

II. COCAINE AND THE YOUNG

Homeless kids comprise probably the most troubled segment of American children and adolescents. At Covenant House we have been accustomed to fighting problems ranging from destitution and emotional disturbance to prostitution—problems which do not seriously threaten most of the young. Cocaine, however, is not one of

consequences of cocaine use as other adolescents. For a discussion of the effects of cocaine, see infra notes 84-150 and accompanying text.


60. Id. app. at 3.


62. HIV Seroprevalence of Adolescents, supra note 59, at 4. There is a strong connection between substance abuse and prostitution among street kids. See ALCOHOL RESEARCH GROUP STUDY, supra note 51, at 43 (noting that 42% of the alcohol-abuse group (which substantially overlapped the drug-abuse group) had been paid for sex, as opposed to only 19% of the non-abusers).

63. Covenant House has no hard evidence on injuries suffered by homeless and runaway kids involved in drug trafficking. Based upon our experiences with runaways, however, such events are frequent and increasing.
those isolated problems. It poses a deadly threat to adolescents and young children of every race and class. To realize the depth of the threat, it is crucial to examine current prevalence and usage patterns of drug use, its effects on those who take it, and the apparent causes for adolescent cocaine abuse.

A. Extent of Cocaine Use by Adolescents

What one clinician called the “cocaine outbreak” of the 1970’s and 1980’s was really an abuse epidemic among the young. In the 1985 National Household Survey on Drug Abuse conducted by the National Institute on Drug Abuse, 25% of eighteen to twenty-five year-olds reported “ever use” of cocaine—compared with a mere 4% of those above thirty-five. According to the survey, over one million youths aged twelve to seventeen had used cocaine in the past—almost 400,000 of them in the previous month. Three million youth under twenty-five years-of-age had used cocaine in the past thirty days. Young cocaine users were typically white, male, and most likely to come from the western United States.

A separate annual survey of a national sample of high school seniors is particularly useful for tracking the inroads of cocaine on adolescents, who by virtue of being in their last year of high school, are sharply distinct from Covenant House’s homeless clients. The 1985 national survey shows a growth in “ever use” of cocaine from 9% of the class of 1975 to 17% of the 1985 class, followed by a decline to 15% of the class of 1987. In the last class, male students were more likely to have used the drug than females. Students without four-year college plans were also more likely to have used cocaine than their more ambitious classmates, but again not by

64. Cohen, Causes of the Cocaine Outbreak, in COCAINE: A CLINICIAN’S HANDBOOK, supra note 19, at 3.
65. 1985 HOUSEHOLD SURVEY, supra note 14, at 14. While recreational use appears to have declined substantially in the face of the crack scare over the past several years, the number of weekly and daily crack users has increased by 48 and 34 percent respectively since 1985. NATIONAL INST. ON DRUG ABUSE, HIGHLIGHTS OF THE 1988 NAT’L HOUSEHOLD SURVEY ON DRUG ABUSE 2 (1988). In the National Household Survey, casual cocaine use by blacks and whites was found nor to have declined significantly from 1985 to 1988. Id.
67. Id.
68. Id.
69. See id. at 14-17.
70. See YOUTH DRUG SURVEY, supra note 31, at 20.
71. Id. at 54.
72. The figures were 16.5% for males to 13.6% for females. Id. at 36.
much.\textsuperscript{73} Use of cocaine in the previous thirty days stood at 4.3\%, with males and less educationally motivated students posting marginally higher rates.\textsuperscript{74} As for crack, which was still a novelty at the time of the survey, 5.6\% of the seniors had "ever" used it, but only 1.5\% had used it in the preceding 30 days.\textsuperscript{75}

The fact that most high school seniors have not used cocaine and only a few have tried crack would be more comforting, if patterns of initiation in late adolescence were not so disturbing. A large random survey of youths in New Jersey found the number of adolescents who have tried cocaine doubled between the ages of eighteen and twenty-one. By twenty-one years-of-age, four in ten females and half of the males had used cocaine at least once.\textsuperscript{76} Even worse, cocaine is, in the words of one research team, "the one illicit drug [that] shows an important increase in active use with age."\textsuperscript{77} Over a three-year period, adolescent users in one major study showed a better than threefold increase in annual days of cocaine use.\textsuperscript{78} There is no "inevitable progression" to heavier use of cocaine by adolescents, but for high school seniors who use cocaine casually, approximately one-quarter will progress to heavier use within the four years.\textsuperscript{79}

Among illicit drugs, cocaine plays an unusually prominent role in the transition to adulthood for young Americans. Unlike any other

\begin{itemize}
\item \textsuperscript{73} The figures were 18.4\% versus 13.2\%. Id.
\item \textsuperscript{74} Id. at 40.
\item \textsuperscript{75} Id.
\item \textsuperscript{76} See White, \textit{Longitudinal Patterns of Cocaine Use Among Adolescents}, 14 \textit{Am. J. Drug & Alcohol Abuse} \textbf{1}, 7 (1988); see also O'Malley, Johnston & Bachman, \textit{Cocaine Use Among American Adolescents and Young Adults} in \textit{Cocaine Use in America: Epidemiologic and Clinical Perspectives} 50, 63 (National Institute on Drug Abuse Research Monograph Series No. 61, 1987)[hereinafter NIDA Research Monograph No. 61] (noting a "striking" increase in cocaine use post high school graduation compared with stable or decreased use of other illicit drugs).
\item \textsuperscript{77} \textit{Youth Drug Survey}, \textit{supra} note 31, at 230.
\item \textsuperscript{78} White, \textit{supra} note 76, at 9 (finding that the amount of cocaine consumed also increased from an average of four lines per use of cocaine to an average of six lines); see Chitwood, \textit{Patterns and Consequences of Cocaine Use}, in \textit{NIDA Research Monograph No. 61, supra} note 76, at 111, 118 (finding 48\% of the cocaine-using population eventually progressed to higher use).
\item \textsuperscript{79} \textit{NIDA Research Monograph No. 61, supra} note 76, at 65-66 (finding that of the 6.63\% of high school students using cocaine one to nine times in their senior year, 24\% of those seniors used cocaine ten times annually four years later); see also Siegel, \textit{Changing Patterns of Cocaine Use: Longitudinal Observations, Consequences, and Treatment} in \textit{Cocaine: Pharmacology, Effects, and Treatment of Abuse} 92, 100-101 (National Institute on Drug Abuse Research Monograph Series No. 50, 1987) [hereinafter \textit{NIDA Research Monograph No. 50}](explaining that 18\% of social users became "intensified" or "compulsive" users over a five-year period).
\end{itemize}
illicit drug, the risk of initiating cocaine use does not peak in the mid to late teens, but continues to increase until the mid twenties.\textsuperscript{80} Like many other drugs, cocaine use cuts across normal lines of class, race and education.\textsuperscript{81} The price of cocaine, however, has fallen in sharp contrast with all other illicit substances. Justice Department estimates reported the illegal market retail price of cocaine dropped from $640 a gram in 1977 to $100 a gram in 1987, while during that same period the price of heroin rose 43\%, LSD increased 143\%, amphetamines increased 576\% and marijuana increased 491\%.\textsuperscript{82} After the extraordinary drop in price, combined with the invention of crack, cocaine finally came within the economic reach of millions of consumers with low disposable incomes, most notably adolescents at every level of society and every kind of neighborhood.\textsuperscript{83}

\section{B. Effects of Cocaine Abuse}

The cocaine epidemic of the 1980's has coincided, fortunately, with broad scholarly attention to the effects of its use. Once thought almost entirely benign,\textsuperscript{84} and still highly useful as a local anesthetic in operations of the ear, nose and throat,\textsuperscript{85} cocaine has now definitively been exposed for its addictive, toxic and devastating psychosocial effects on those who abuse it as well as on their children. Careful attention to the literature reveals that those injuries are visited with special severity on adolescents.

1. \textit{Pharmacology}.— Cocaine is present in two bushes, \textit{erythroxylon coca} and \textit{erythroxylon novogranatense}, and is extracted through organic solvents, separation and recrystallization.\textsuperscript{86} From its

\textsuperscript{80} Kandel, Murphy \& Karus, \textit{Cocaine Use in Young Adulthood: Patterns of Use and Psychosocial Correlates}, in NIDA \textit{RESEARCH MONOGRAPH} No. 61, \textit{supra} note 76, at 76, 82.

\textsuperscript{81} See O'Malley, Johnston \& Bachman, \textit{supra} note 76, at 67-69 (indicating no significant differences in marijuana or cocaine use by sex or race, but a slightly higher use of cocaine and not of marijuana by children of better educated parents); Skager \& Fisher, \textit{Substance Use Among High School Students in Relation to School Characteristics}, 14 \textit{ADDICTIVE BEHAVIORS} 129, 132-34 (1989) (finding that substance use is highest in rural or small town high schools and lowest in large, low-income, high minority enrollment high schools).


\textsuperscript{84} See Gawin \& Ellinwood, \textit{supra} note 4, at 1173; \textit{supra} notes 4-7 and accompanying text.

\textsuperscript{85} Brain \& Coward, \textit{supra} note 7, at 444-46. The "Brompton Cocktail," a mixture of morphine with cocaine, is sometimes given to terminally ill patients with intractable pain. \textit{Id.} at 443.

\textsuperscript{86} \textit{Id.} at 432; see also Jones, \textit{Psychopharmacology of Cocaine}, in \textit{COCAINES: A CLINI-
crystallized form, cocaine can be taken orally, nasally, via injection or by smoking. 87 Each method involves somewhat different pathways of absorption, but in all of them cocaine readily enters the body. 88 Cocaine is detectable in the blood within a few minutes after chewing or sniffing. 89 Injecting or smoking cocaine, however, delivers the drug to the brain in less than thirty seconds. 90

How cocaine affects the brain is not understood with absolute confidence, 91 but its major effect seems to be as a local anesthetic. 92 More importantly, cocaine acts as a chemical block to “reuptake” of dopamine, norepinephrine and serotonin. 93 Dopamine and norepinephrine play key roles in the brain’s “pleasure centers” or reward mechanisms. The release of dopamine and norepinephrine into the “synapse”—the narrow space between neurons—provides a sense of pleasure and well-being. 94 Serotonin is involved in arousal, mood, and aggression functions. 95 The process of “reuptake” occurs where dopamine, norepinephrine and serotonin, which are normally released in limited doses, are partially retrieved by the releasing neuron and stored for reuse. 96 Cocaine blocks reuptake, causing intense feelings of euphoria because large quantities of norepinephrine, serotonin and especially dopamine, are consumed rather than retrieved. 97 Further ingestion of cocaine prolongs euphoria by stimulating con-

87. Jones, supra note 86, at 57; Gawin & Ellinwood, supra note 4, at 1175.
88. For a review of the different avenues of cocaine absorption, see Jones, The Pharmacology of Cocaine, in NIDA Research Monograph No. 50, supra note 79, at 37-45.
89. Id. at 42-45.
90. Id. at 44-45.
91. Id. at 41. Because of its toxic and dependence potential, cocaine cannot easily be researched using human subjects. Thus, much of what is known about its psychopharmacological properties is the result of animal studies. See Grabowski, Cocaine 1984: Introduction and Overview, in NIDA Research Monograph No. 50, supra note 79, at 3-4.
94. Id. at 74, 76-79; see Wyatt, Karoum, Suddath & Hitri, The Role of Dopamine in Cocaine Use and Abuse, 18 Psychiatric Annals 531, 531-532 (1988); Wise, Neural Mechanisms of the Reinforcing Action of Cocaine, in NIDA Research Monograph No. 50, supra note 79, at 15, 19-21.
95. Extein & Dackis, supra note 93, at 79.
96. Id. at 74; Wyatt, Karoum, Suddath & Hitri, supra note 94, at 531-533.
97. See Extein & Dackis, supra note 93, at 76-77 (stating that “the data suggest that DA [dopamine], not NE [norepinephrine], mediate the reinforcing or euphoric effects of cocaine.”); Wyatt, Karoum, Suddath & Hitri, supra note 94, at 531-32; Wise, supra note 94, at 19-22.
tinued release of dopamine into the synapse. During a binge, dopamine is eventually depleted to extremely low levels resulting in a "crash"—i.e. major depression and exhaustion.

Crack is the most efficient form of cocaine, both in delivering euphoria and bringing the crash. Its pleasurable effects begin within seconds after it is inhaled, but the euphoria lasts only about 20 minutes. In contrast, the "highs" associated with nasal or oral cocaine injection last for one to two hours, but are apparently not nearly as intense or pleasurable. As one former crack user explained: "The high [with crack] was a different high than when I sniffed cocaine . . . The high made me feel like I was floating and gave me a head rush, and nothing would bother me when I felt like that." From the standpoint of the crack sellers, as one public health official tersely put it: "[Crack] is better; it is cheaper; the customer supply is exhausted more quickly; and, finally, the effect is perceived as being more pleasurable."

2. Addictive Properties.—Cocaine's power to produce extraordinary pleasure is precisely its most insidious characteristic. As one clinician stated: "If some sinister master chemist wanted to design a drug that would predictably entrap large numbers of its users, it would resemble cocaine. Cocaine scores a '10' on the euphoria scale." The degree of cocaine's "reinforcing" quality—its capacity to produce pleasure chemically—is higher than any other illicit substance except perhaps heroin. For this reason alone, a cocaine habit is easy to acquire and hard to break.

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98. Wyatt, Karoum, Suddath & Hitri, supra note 94, at 532-33.
101. Id.; see Siegel, Cocaine Smoking: Nature and Extent of Coca Paste and Cocaine Free-Base Abuse, in COCAINE: A CLINICIAN'S HANDBOOK, supra note 19, at 175, 184-85 (discussing the attraction and chronic physical effects from smoking cocaine).
102. See Joint Crack Hearings, supra note 37, at 14-15 (quoting testimony of Lee Ann Bonanno, a recovering crack user).
103. Id. at 82 (quoting the testimony of John French, Chief, Office of Data Analysis and Epidemiology, Alcohol, Narcotic, and Drug Abuse Unit, New Jersey State Department of Health).
104. Cohen, supra note 64, at 6.
105. Wise, supra note 94, at 15.
106. Id. at 24-27. As one researcher noted, "it would appear that the mood elevation associated with cocaine and opiates in nondependent subjects is sufficiently powerful to account for the initial acquisition of drug self-administration habits and is likely to account as well for
Recent research indicates that cocaine is also addicting because of the negative effects that occur once regular use is discontinued. The negative effects may be traced, in part, to the depletion of dopamine in the brain during a “binge.” Whatever the cause of addiction, or more properly, the “stimulant-abstinence syndrome”—its existence is now well accepted. The syndrome is broken into three phases: (1) a “crash” phase following a binge involving intense depression and extreme exhaustion; (2) a “withdrawal” phase lasting several weeks or months, which is marked by lack of energy, interest in the environment, and the ability to experience pleasure; and (3) an “extinction” phase continuing months or years in which craving for cocaine periodically appears. The theory that cocaine has substantial addictive potential for many users is no longer in dispute. Adolescent users appear to be at special risk. One major survey found that an adolescent’s “vulnerability to the dependence-producing properties of the drug and to disruption of functioning may be greater than that of adults.”

3. Toxicity.— Deaths from cocaine overdoses have skyrocketed

the rapid reacquisition of such habits in detoxified subjects.” Id. at 27.
107. Wyatt, Karoium, Suddath & Hitri, supra note 94, at 532-33; Extein & Dackis, supra note 93, at 79-80.
108. Gawin & Ellinwood, supra note 4, at 1176 (noting that “the existence of a stimulant-abstinence syndrome is generally accepted” and involves a “three phase pattern.”).
109. Id. The “crash period” consists of depression, agitation and anxiety. Id. For one to four hours, a craving for stimulants will exist which will later be supplanted by a craving for sleep. Id. The craving for sleep may lead to the use of a narcotic to induce sleep and for three to four nights following a crash period, increases in rapid eye movement will occur during sleep. Id. During this period, suicidal behavior may occur. Id.
110. Id. The withdrawal symptoms often include decreased energy, limited interest in the environment, and limited ability to experience pleasure and they increase in intensity during the 12 to 96 hours following the crash. Id. During this period, the symptoms may fluctuate in their severity, and for six to eighteen weeks, the individual may suffer from a strong drug craving. Id. Recreational users, however, may find that they will not suffer from severe withdrawal symptoms since the severity of symptoms depends on the duration and amounts abused. Id.
111. Id. Cravings are “evoked by circumstances (moods, people, locations, other intoxicants) and objects (money, white powders, pipes, mirrors, syringes) that cue conditioned associations to memories of stimulant euphoria.” Id.
112. See Jones, supra note 86, at 67; supra notes 4-7 and accompanying text. It should be noted, however, that cocaine does not produce “tolerance” (decreased sensitivity to the same dose) in the straightforward way that heroin does, but in a very complex manner that is not fully understood. Id. at 65-66. Indeed, some of cocaine’s effects can increase over time with the same dosage, a phenomenon known as “kindling.” Id.
113. Washton & Gold, supra note 83, at 18; see Abelson & Miller, A Decade of Trends in Cocaine Use in the Household Population, in NIDA RESEARCH MONOGRAPH NO. 61, supra note 76, at 35, 41.
since the 1970's, rising from one or two per year in Dade County, Florida in the early 1970's, to nearly two per week in 1986. One of the most lethal aspects of cocaine is that it is virtually impossible to define what constitutes an "overdose"; even small doses can be fatal to those deficient in certain key bodily enzymes. Cocaine acts as a strong stimulant on the cardiovascular system and, therefore, can be quickly fatal even in limited quantities to those with any form of cardiovascular disease. Cocaine-induced excited delirium followed by sudden death is perhaps the newest known horror of the drug. It is a reaction in which the victim becomes suddenly paranoid, unexpectedly strong and violent, and after thrashing about for a brief time suddenly dies. Less dramatically, but perhaps more crucial to the physical effects on most users, is cocaine's disruption of the brain's reward mechanisms which interferes with normal appetites for food, water and sleep. All these physical effects hit adolescents with special force because of their lower body weight and ongoing physical development.

Each form of using cocaine has special physical hazards. According to one summary, the unique effects of smoking the drug include:

[C]oughing with black or bloody expectorate, dysarthria, slurred speech, sore throat, wispy voice, thirst, muscle pains in the lower back and neck, dry skin and/or lips, bleeding gums, chest pains, respiratory difficulties, dyspnea on exertion, dizziness, episodic unconsciousness, urination difficulty, visual disturbances, edema, and other skin disturbances.

115. Id. at 37.
116. Id. at 45-46.
117. An "[e]xcited delirium is not a primary psychiatric problem but a mental aberration secondary to a drug or a disease process." Id. at 47.
118. Id. at 47-49.
119. Wise, supra note 94, at 21-22, 25, 27; see Washton & Gold, supra note 83, at 14, 18 (describing some of the serious medical and social problems attributable to cocaine use).
120. Gold, Washton & Dackis, Cocaine Abuse: Neurochemistry, Phenomenology, and Treatment, in NIDA RESEARCH MONOGRAPH No. 61, supra note 76, at 140.
121. Siegel, supra note 101, at 184; see also Eurman, Chest Pain and Dyspnea Related to "Crack" Cocaine Smoking: Value of Chest Radiography, 172 RADIOLOGY 459 (1989) (describing abnormalities detected in chest X-rays of crack smokers); Tashkin, Simmons, Coulson, Clark & Gong, Respiratory Effects of Cocaine "Freebasing" Among Habitual Users of Marijuana With or Without Tobacco, 92 CHEST 638, 642 (1987) (describing some acute respiratory symptoms associated with cocaine freebase smoking not reported by marijuana smokers with or without tobacco who did not freebase cocaine).
"Snorting" can lead to perforation of the nose and eventually to the collapse of the major nasal structures, as well as severe infections and inflammations of the sinuses and lungs.\textsuperscript{122} Injecting cocaine can lead to severe bacterial and fungal infections in various internal organs.\textsuperscript{123} In the view of one specialist, the needle-sharing that accompanies intravenous cocaine abuse is "one of the major ways in which AIDS has entered the middle-class heterosexual population."\textsuperscript{124}

4. Psychosocial Consequences.— Adolescents who use cocaine and other illicit substances also appear to suffer effects that, while not medical in nature, are nonetheless brutally real. Adolescent callers to the national cocaine hotline reported strikingly negative effects on their school performance and attendance; thirty-one percent had been "expelled for cocaine-related difficulties."\textsuperscript{125} One in seven callers reported cocaine-induced automobile accidents and a like number described having attempted suicide as a consequence of using the drug.\textsuperscript{126}

Two major longitudinal studies of adolescent substance abuse show other effects. The first study tracked a group of 118 cocaine users (originally aged eighteen to thirty-eight) from 1975 until 1983, and demonstrated that those involved with intensified or compulsive use suffered substantial psychological problems.\textsuperscript{127} The compulsive users, in particular, began to exhibit a paranoid profile with depression, social maladjustment, and poor impulse regulation.\textsuperscript{128} The second study focused on 654 individuals from early adolescence to young adulthood and found a wide variety of negative emotional, social and educational or vocational outcomes associated with adolescent drug use.\textsuperscript{129} The authors concluded that "successful achievement of many of [the] critical developmental tasks of adolescence may be jeopardized by drug use."\textsuperscript{130} This view seems to be an under-

\textsuperscript{122} Estroff, \textit{Medical and Biological Consequences of Cocaine Abuse}, in \textit{Cocaine: A Clinician's Handbook}, supra note 19, at 27.

\textsuperscript{123} \textit{Id.}

\textsuperscript{124} \textit{Id.} at 28.

\textsuperscript{125} Washton & Gold, supra note 83, at 18.

\textsuperscript{126} \textit{Id.}

\textsuperscript{127} Siegel, supra note 101, at 185-86.

\textsuperscript{128} \textit{Id.} at 185.

\textsuperscript{129} Newcomb & Bentler, \textit{Impact of Adolescent Drug Use and Social Support on Problems of Young Adults: A Longitudinal Study}, 97 J. Abnormal Psychology 64 (1988). Adolescent use of cocaine was uniquely associated with work problems later in life. \textit{Id.} at 70.

\textsuperscript{130} \textit{Id.} at 72; see Newcomb & Bentler, \textit{Cocaine Use Among Young Adults}, 6 \textit{Advances in Alcohol \\& Substance Abuse} 73, 80-84 (1986).
statement most especially because substance abuse is a significant factor in teenage suicides.  

5. Cocaine, Infants and Toddlers.— If the health and personal development of teenagers is endangered by cocaine and other illicit drugs, this seems but a minor tragedy, compared with the damage drug abuse inflicts on the children they bear. Infants born of mothers using cocaine are at a grave risk of having low birthweight and small head circumference—both key factors in predicting later development problems. Indeed, the first follow-up studies of such infants into childhood have revealed shattering long-term effects of prenatal cocaine exposure—effects that are, in the words of one researcher, “interfering with the central core of what it is to be human.”

Often these infants are removed from their mothers’ care because of drug abuse only to suffer the dismal fate of “boarder babies,” deprived of consistent loving attention. If the babies remain in or are returned to their mothers’ care, they are at extremely high risk of suffering abuse or neglect, as are other children whose mothers become addicted to cocaine after they are born.

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131. See Czechowicz, Adolescent Alcohol and Drug Abuse and Its Consequences—An Overview, 14 AM. J. DRUG & ALCOHOL ABUSE 189 (1988) (stating that “[a]lcohol and other drug abuse has the most serious impact on developing children and youth” and suggesting that “initiating drug use at an early age can have far-reaching physical, psychosocial, and developmental consequences.”).

132. Klerman, Clinical Epidemiology of Suicide, 48 J. CLINICAL PSYCHIATRY 33, 37 (1987). Remarkably, substance abuse is more significant as a risk factor for suicide than psychiatric disorders, including depression. Id.

133. Use of alcohol or marijuana by teenagers is associated with a significantly higher risk of initiating sexual intercourse during the following year. Mott & Haurin, Linkages Between Sexual Activity and Alcohol and Drug Use Among American Adolescents, 20 FAM. PLAN. PERSP. 128, 133 (1988).

134. Zuckerman, Frank, Hingson, Amaro, Levenson, Kayne, Parker, Vinci, Aboagye, Fried, Cabral, Timperi & Bauchner, Effects of Maternal Marijuana and Cocaine Use on Fetal Growth, 320 NEW ENG. J. MED. 762, 762 (1989); House Hearings, supra note 100, at 173-179 (quoting testimony of Toni Shamplain, Director of Addictions and Preventative Health Services, Family Health Center, Inc., Miami); see also, Amaro, Zuckerman & Cabral, Drug Use Among Adolescent Mothers: Profile of Risk, 84 PEDIATRICS 144 (1989) (suggesting that drug use among adolescent mothers is an important factor associated with an infant’s later negative social and medical characteristics).


137. In fiscal year 1987, for example, New York City provided care for 2,002 infants confronting withdrawal, and 4,523 abuse and neglect cases related to substance abuse. Both represented major increases from the previous year—54% and 72%, respectively. CITY OF NEW YORK, HUMAN RESOURCES ADMIN., THE CONSOLIDATED SERVICES PLAN: FISCAL YEARS
6. Cocaine and Crime.—The public is also at special risk from cocaine and crack use, especially by kids in late adolescence. Youth aged sixteen to twenty-one make up 9.2% of the nation's population, but comprise 26.5% of all those arrested for criminal offenses. Thus, adolescents represent an especially high risk for criminal behavior and cocaine is likely to provide the fertile soil for the commission of crimes.

In part, of course, a cocaine habit creates pressure to commit crimes simply to support such a habit. In one study, 45% of adult users and 31% of adolescents reported that they had stolen from their families, friends or employer to support their habits. In another study, 96% of adolescent heavy cocaine users admitted to stealing for drug money. Adolescents appear more likely than adults to support their habit by selling drugs and through prostitution. This is not very surprising considering that a cocaine habit costs an average of $600 or more per week.

Unlike most other addictive drugs, cocaine has a potential for provoking irrational and violent behavior that makes its relation to criminal behavior especially sinister. More than one in four teenage callers to the national cocaine hotline reported cocaine-related violent behavior. As a 20-year-old former user stated: "If someone annoyed me when I was high on crack, I would start a fight with them, or I felt like I wanted to kill them. Crack made me a very violent person, something like Dr. Jekyll and Mr. Hyde."

138. DEPARTMENT OF JUSTICE SOURCEBOOK, supra note 82, at 484. No other age group has such a disproportionately high arrest rate.

139. Washon & Gold, supra note 83, at 18.

140. Smith, Schwartz & Martin, Heavy Cocaine Use by Adolescents, 83 PEDIATRICS 539, 540 (1989) (stating that 43% of the cocaine users admitted to having stolen over $1000 worth of goods).

141. See Washon & Gold, supra note 83, at 18.

142. Smith, Schwartz & Martin, supra note 140, at 540 (noting that 11% of heavy adolescent users supported their habit through prostitution).

143. Washon & Gold, supra note 83, at 13.

144. Most dramatically, it can produce hallucinations and violent psychosis. See Estroff, supra note 122, at 29-30 (stating that these symptoms can occur when high levels of cocaine are present in the blood). In a large majority of users, the drug's stimulant effects include: "disinhibition, impaired judgment, grandiosity, impulsiveness, hypersexuality, hypervigilance, compulsively repeated actions, and extreme psychomotor activation" that often "result in accidents, illegal acts, or atypical sexual behavior." Gawin & Ellinwood, supra note 4, at 1175 (noting that such effects occur in more than 80% of all regular cocaine users).

145. Joint Crack Hearings, supra note 37, at 15 (testimony of Lee Ann Bonanno, a recovering crack user).

146. Id.
In sum, cocaine is a drug with unique power over the human brain.\textsuperscript{147} It is addictive and destructive to a substantial proportion of those who use it.\textsuperscript{148} If adolescents are particularly vulnerable to its habit-forming and harmful effects, their children are far more tragic victims, harmed both in and out of the womb often beyond hope of full recovery.\textsuperscript{149} Meanwhile, the non-using public is held hostage to the violent outbursts of those in the drug's thrall.\textsuperscript{150}

C. Causes of Adolescent Cocaine Abuse

Given these plain facts, why do adolescents experiment with cocaine in the first place and then flirt with self-destruction by using it recreationally? If we are to have any hope of protecting the young from their poor judgment, whether by criminal law or other instruments of social policy, it is crucial to have some understanding of the etiology of cocaine abuse. However, a brief overview of the leading theories on why adolescents turn to illegal drugs suggests that such an understanding is a long way off. Only one factor, the availability of the drug itself, can confidently be linked to the prevalence of use.

1. Leading Theories of Adolescent Drug Abuse.— Virtually all scholars agree that adolescent drug use cannot be explained solely by socioeconomic or racial factors.\textsuperscript{151} With over half of American youth from every race, ethnic group and class having tried at least one illicit drug,\textsuperscript{152} such an approach seems inherently implausible. Cocaine, moreover, presents a difficult problem to one proposing that drug abuse is a response to social and economic deprivation; in 1985 whites were more likely than blacks to have tried cocaine.\textsuperscript{153}

   Toward the other end of the spectrum are “psychological” theo-

\textsuperscript{147} See supra notes 91-113 and accompanying text.
\textsuperscript{148} See supra notes 104-13 and accompanying text.
\textsuperscript{149} See supra notes 113, 125-37 and accompanying text.
\textsuperscript{150} See supra notes 138-46 and accompanying text.
\textsuperscript{151} See Oetting & Beauvais, Common Elements in Youth Drug Abuse: Peer Clusters and Other Psychosocial Factors, 17 J. DRUG ISSUES 133, 135, 143-44 (1987). Elements at every socioeconomic level, including family strength, school adjustment, deviant role models, and access to drugs, will all factor into the level of drug use in an area. Id. Moreover, these factors are not the exclusive domain of the lower class. Id.
\textsuperscript{152} Czechowicz, supra note 131, at 190.
\textsuperscript{153} 1985 HOUSEHOLD SURVEY, supra note 14, at 14-15; see also Skager & Fisher, Substance Use Among High School Students in Relation to School Characteristics, 14 ADDICTIVE BEHAVIORS 129, 136 (1989) (explaining that white students at rural high schools are most likely to abuse drugs, followed by white students at suburban high schools and finding the lowest levels of abuse existed among students at low-income, predominantly urban minority schools). But see Kandel, Murphy & Karus, supra note 80, at 89 (stating that cocaine and other illicit drug users are disproportionately on public assistance).
ries that attempt to attribute substance abuse to the internal psychological needs of individual adolescents. These fall into two general camps. One camp asserts that adolescent drug abuse is essentially a "self-medication" response to depression or a significant psychiatric problem. The other camp holds that "sensation-seeking" is the psychological factor most crucial in determining which adolescents use and which do not. Each theory has serious weaknesses. The "self-medication" theory cannot begin to explain why youth take a wide variety of drugs and why most drugs (especially cocaine) are used sporadically, instead of consistently. The "sensation-seeking" approach flounders in the face of strong evidence that substance abuse has not been clearly linked to any personality type. Both camps fail to explain why drug use rises so quickly in mid to late adolescence and, then subsides by the late twenties. Certainly, if substance abuse were intentionally linked to major personality traits or psychological needs, the abuse would not disappear so rapidly.

An alternate and perhaps better supported approach to explaining adolescent substance abuse looks at particular relationships and patterns of previous conduct. Strong evidence can be mustered that substance abuse can be predicted in direct proportion to the strength of relationships with delinquent peers. Less important is the strength of conventional bonds to parents and others which can attenuate, but not eliminate the effects of delinquent bonding. Likewise, current substance abuse is highly related to past abuse. Indeed, some studies have found past substance abuse to be the sole significant predictor of future drug-related behavior. Conceivably, these


156. Oetting & Beauvais, supra note 151, at 135.

157. Id.

158. Kandel, Murphy & Karus, supra note 80, at 82-83.


160. D. Elliott, D. Huizinga & S. Ageton, supra note 159, at 145. If the youth have strong conventional bonds, however, the probability of delinquent bonding is decreased. Id.

161. This is generally known as the "gateway" theory, which views less serious drug abuse as a gateway to more serious abuse. See Kandel, Murphy & Karus, supra note 80, at 103-06; Newcomb, Fahy & Skager, Correlates of Cocaine Use Among Adolescents, 18 J. Drug Issues 327, 344 (1988); see also D. Elliott, D. Huizinga & S. Ageton, supra note 159, at 117.
two approaches may simply be saying the same thing in different ways: adolescents with a high past of drug use were likely involved in delinquent peer groups and vice versa. What neither of these formulations explains, unfortunately, is how the first involvement with delinquent peers or the first use of drugs occurs. Once a youth has crossed those thresholds, neither approach readily suggests how the damage can be limited or undone. In a sense, these theories can seem true but dangerously close to trivial, at least as guides to shaping public policy.

2. The Crucial Role of Availability.— In another sense, past drug use and delinquent peer group involvement are not trivial “causes” of current drug use at all. In different and imperfect ways they measure the one factor that appears most clearly tied to kids’ use of illicit drugs, and in particular of cocaine—its availability. Only when availability is considered directly is it possible to begin shaping effective strategies to limit the damage of the drug on youth.

Both experimental and clinical evidence strongly suggest that availability is, for many consumers, the only limit on cocaine’s use. In studies with laboratory animals, including monkeys, cocaine’s reinforcing qualities and dependence potential have been such that, “where there are no outside restraints on drug availability, animals can suddenly increase their drug-taking behavior to the point of severe toxicity. In contrast, the intake of cocaine under other conditions (i.e., limited access) is surprisingly regulated.” Clinical studies of humans indicate the same fact: “When drug access is unlimited, cocaine and amphetamine have the same ability to dominate behavior, reducing other behaviors such as feeding and sleeping

162. If theories about class or psychology are true, it is possible to attempt to redress economic differences or provide therapy. In these statistically-based formulations, however, we are at the mercy of past events over which we have no control.

163. Thus, it has been suggested that drug and delinquency prevention programs concentrate on keeping delinquent youth away from each other. D. ELLIOTT, D. HUIZINGA & S. AGETON, supra note 159, at 148-52. However, how are we to know who is “delinquent” and who is not at the beginning? Moreover, once we do know, are we not risking the virtue of the nondelinquents if we permit them to associate with their less angelic peers?

164. Past drug use levels by an individual is likely to represent, from a different angle, past availability of drugs to that person, which may well reflect on current availability. Likewise, because “delinquency” is in significant part defined by use of illicit drugs the degree of an individual’s associations with “delinquents” is likely to track closely the availability of drugs in his milieu. See D. ELLIOTT, D. HUIZINGA & S. AGETON, supra note 159, at 118 (arguing that delinquency and drug use are the best predictors of each other).

165. Johanson, Assessment of the Dependence Potential of Cocaine in Animals, in NIDA RESEARCH MONOGRAPH No. 50, supra note 79, at 62; see Gawin & Ellinwood, supra note 4, at 1175.
and, in the process, reducing stress resistance to life-threatening levels. It is, therefore, the consistent opinion of medical professionals that limited access plays a crucial role in preventing self-immolation through endless binging. In a large survey of adolescent cocaine users, "[n]early all the subjects said that the only limit on their cocaine use was money: [i]f they had more money, they would use more cocaine."

The strong relationship for adolescents between availability and use of illicit drugs may also be illustrated through statistical measures. Every year since 1975 a national survey of high school seniors has been conducted which asks about the frequency of their use of various drugs. The survey also asks the seniors how easy they think it would be to get each of the drugs they wanted. Although these figures may be crude measures of use and availability, because the same questions are asked every year, the rate of change from year to year may nevertheless provide a more robust link with reality. We examined the rate change, charting against each other "annual use" and "availability" figures from 1975 to 1988 for LSD, cocaine, and marijuana, respectively. These "scatter-plot" graphs follow as figures 1, 2, and 3:

166. Wise, supra note 94, at 27.
167. Schnoll, Karrigan, Kitchen, Daghestani & Hansen, Characteristics of Cocaine Abusers Presenting for Treatment, in NIDA RESEARCH MONOGRAPH No. 61, supra note 76, at 175 (arguing patients would have used more cocaine if it were available); see also Gawin & Ellinwood, supra note 4, at 1175; Morehouse, Treating Adolescent Cocaine Abusers, in Cocaine: A CLINICIAN'S HANDBOOK, supra note 19, at 136 (arguing increased availability of cocaine as one of the principal reasons for greater adolescent use in recent years).
168. See Washton & Gold, supra note 83, at 18.
169. YOUTH DRUG SURVEY, supra note 31, at 54.
170. Id. at 66.
171. For a fuller version of this argument and a defense of the "self-report" measures in themselves, see YOUTH DRUG SURVEY, supra note 31, at 20-21.
Figure 3
Marijuana Use v Availability
Use by High School Seniors (1975-88)

Prevalence

Availability

Data from NIDA (1989)
As is evident from the graphs, there exists a highly significant, positive correlation between use and availability for each of these three drugs. Indeed, 70.5% of the prevalence of marijuana can be “explained” by the students’ reports on ease of availability. For cocaine, the percentage of use “explained” by availability is 38%; for LSD, 60.2%. These computations also permit us to project what levels the use of each of the drugs would reach if availability were 100%. For marijuana, “annual use” levels would be projected to reach 75%; for cocaine, 23%; for LSD, 17%. These levels are, for marijuana, 50 percent higher than those of the class of 1988; for cocaine and LSD they are almost double the 1988 “annual use” figures.

Correlational evidence by itself cannot prove cause and effect, but as discussed, the relationship between adolescent use and availability is strongly supported by experimental and clinical evidence as well. Obviously, the causal relationship cannot be in only one direction. Greater demand for the drug would no doubt increase efforts by the underworld to make it more available. Further, the easy availability of a substance does not, in itself, explain why a teenager would first decide to use drugs. Therefore, it can form, at best, only a partial theory of the etiology of adolescent substance abuse. That said, however, clearly the evidence runs strongly in favor of availability playing a substantial role.

Because of our work with street kids at Covenant House, we are

172. p < .001 in all three cases.
174. R2 = .38; F = 7.425. P = (.22644 x A) .05985. Significance of F < .02. The correlation for cocaine use and availability, while still clearly significant, is somewhat lower than for the other two drugs for two reasons, one of which may be peculiar to the last two or three years. First, with the barrage of publicity over the war on cocaine, high school students shied away from its use; but also, in part, because of its high media profile, students seemed to believe it was readily accessible. We suggest that as publicity subsides, the correlation between perceived availability and personal use will be as strong for cocaine as for the other drugs under study. Indeed, even through the class of 1987, such was the case: from 1975 to 1987, fully 65.1 percent of cocaine’s use level in any year could be statistically “explained” by the level of its availability. (P < .001) Second, we note that high school students using crack or cocaine have extremely high drop-out and expulsion rates. See supra note 125 and accompanying text. Thus surveys of high school seniors may be less reliable regarding cocaine than for marijuana or LSD, which do not seem to have as strong effects on educational stability.
175. R2=.6023; F=18.18. significance of F<.002.
176. YOUTH DRUG SURVEY, supra note 31, at 54.
177. See supra notes 164-67 and accompanying text (discussing surveys and experiments that note the correlation between adolescent drug use and availability).
firmly convinced that cocaine’s availability is the *central* “cause” of its abuse by adolescents. The kids Covenant House helped in 1984 came from backgrounds no less disadvantaged, and from families no less dysfunctional, than those who arrived in 1986 and thereafter. The kids in 1984 had an extremely high rate of psychiatric problems, as do those Covenant House presently sees. In 1984, their past use of illegal drugs was high and their involvement with “delinquent” peers was heavy. Yet, the kids of 1984 were not, except in rare cases, addicted to cocaine or any other hard drug.

The easy availability of cocaine’s high with crack changed the kids into a group plagued by addiction. The change has been too sudden and dramatic to be explained through “self-medication” or “peer group” theories of adolescent substance abuse. Homeless kids are in deep pain and ready to try any remedy—chemical or otherwise. Covenant House’s experience in the 1980’s, however, convinced us that most kids will turn to the destructive cycle of cocaine abuse only when it is readily available. Certainly, they are heavily influenced by their family backgrounds, socioeconomic deprivations and deviant friends, but those external forces will only result in cocaine addiction when cocaine is easily available.

In the face of all the clinical and statistical evidence already cited for homeless adolescents, why should we believe adolescents with homes would be any different? Many kids use cocaine for a dumb, but human and *very* adolescent reason—because it is there. If we are to address seriously the risks of addiction, physical injury, mental breakdown, emotional disability, crime and infant morbidity that describe the experience of cocaine for American adolescents, we must find ways to keep the kids out of harm’s way. We must do everything in our power to prevent their access to cocaine.

### III. Protecting Kids From Cocaine

Neither cocaine’s particular dangers to the young nor the strong connection between its availability and its abuse has been substan-

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178. *See supra* text accompanying notes 101-03.
179. *See supra* notes 154-63 and accompanying text.
180. *See supra* notes 159-63 and accompanying text.
181. *See supra* notes 164-76 and accompanying text.
182. *See supra* notes 26-181 and accompanying text.
183. *See* E. ERIKSON, *IDENTITY YOUTH AND CRISIS* 156 (1968). Erikson notes the the need of older adolescents to take the risks available to them because “through free role experimentation [the adolescent] may find a niche in some section of his society, a niche which is firmly defined and yet seems to be uniquely made for him.”
tially questioned in the recent debate over the drug’s legal status. In our view, however, these factors have too frequently been ignored by both sides of the legalization debate when considering the government’s responsibilities toward its regulation. It is our position that once the special vulnerabilities of children are taken into account, the legalization debate becomes, on its own terms, rather easy to resolve—but those terms appear increasingly perverse and shortsighted. Beyond cocaine’s legal status, it is crucial for the government to attack the current disarray of policies toward alcohol and nicotine abuse by adolescents, and to focus carefully on prevention and treatment strategies to protect kids at risk.

A. Criminal Sanctions

If, as we believe, the evidence conclusively indicates cocaine can enslave, unhinge and kill those who use it—even with what seems to be good judgment at first—then cocaine has no place in the lives of this country’s children and adolescents. We have the evidence of the past fifteen years, from among kids in both good and bad homes and those on the street, to tell us of cocaine’s special horrors when abused by the young.184 Through our work at Covenant House, we have enough knowledge and common sense, to understand that drug abuse by teenagers is intimately connected to its availability.185

We also know that criminal law is capable of substantial success in reducing, but not eliminating, the availability of drugs.186 Thus, Prohibition, though usually judged as an overall failure, was highly successful in reducing the consumption of alcohol.187 Indeed, during its reign the death rates from acute alcohol overdose and liver cirrhosis declined dramatically, to levels not observed before or since Prohibition.188 Current research has shown the same effect in individual counties that prohibit the sale of alcohol. Such counties have significantly lower death rates from liver cirrhosis and from suicide, two key indicators of alcohol consumption.189

184. See supra notes 84-132, 138-50 and accompanying text.
185. See supra notes 164-82 and accompanying text.
186. Arguments Against Legalizing Drugs... And A Proposed Solution, DRUG ABUSE UPDATE, Sept. 1988, at 18 (statement of Leroy Zimmerman, attorney general of Pennsylvania).
187. Aaron & Musto, supra note 12, at 164-65 (discussing prohibition’s effect in sharply reducing the rate of alcohol consumption in the United States).
188. Id. at 165 (discussing the reduction in deaths attributed to cirrhosis).
Given the proven, if limited, power of the criminal law to reduce availability and the effective consensus on cocaine's harmfulness to children and adolescents, it is hardly surprising that no one, at least to our knowledge, has seriously proposed legalization of cocaine distribution to minors. To be sure, few proponents of decriminalization find enough time to discuss the issue even in passing; most, it may safely be assumed, would adopt the same legal restrictions on cocaine use by minors that currently apply to alcoholic beverages. As Mike Royko succinctly put it in arguing for legalization: "We can view drugs the way we view liquor. If you want it, and are of legal age and have the price, you can have booze."

Unhappily, even the most passing acquaintance with the use of alcohol by American adolescents suggests the absurdity of this strategy, at least, if it is genuinely meant to protect kids from drug abuse. By the time kids have finished the twelfth grade, 92% of teenagers have used alcohol. Indeed, well over 50% of teenagers first use alcohol by the end of ninth grade. Most kids have been drunk by the end of tenth grade and one third of seniors report having had five or more drinks in a row during the previous two weeks.

Cigarette use is also instructive. Two-thirds of all teenagers have smoked tobacco at least once by the end of high school. Almost a fifth of all teenagers smoke cigarettes daily in the twelfth grade, and more than one senior high school student in ten smokes half a pack or more every day. Teenage smoking occurs despite the fact that most states outlaw the sale of cigarettes to minors.

By comparison, drugs that are forbidden to both adults and minors are far less prevalent among the young. The number of youth

190. See supra notes 84-149 and accompanying text.
192. YOUTH DRUG SURVEY, supra note 31, at 94.
193. Id.
194. Id.
195. Id. at 57, 94.(concluding that the actual range is from a high of 41.4% in 1981 to a low of 34.7% in 1988).
196. Id. at 54. (reporting that cigarette use varied from a high of 75.7% in 1977 to a low of 66.4% in 1988).
197. Id. at 57. Twenty-eight percent of seniors report cigarette use in the previous 30 days, indicating an even larger pool of long-term smokers. Id. at 56.
using marijuana in the previous thirty days is less than a third of those using alcohol.\textsuperscript{199} Seniors' daily use of marijuana is less than one sixth of the daily use of cigarettes.\textsuperscript{200} For cocaine, the difference is far wider: lifetime prevalence in the class of 1988 stood at 12.1%; thirty-day prevalence at 3.4% (versus 63.9% for alcohol); daily prevalence at 0.2% (versus 4.2% for alcohol and 18.1% for cigarettes).\textsuperscript{201}

These differences speak powerfully in favor of maintaining the current use of the criminal law to protect adolescents and children from the cocaine epidemic. Given the powerful addictive and reinforcing qualities of cocaine and crack, and what we know about alcohol and cigarettes abuse by the young, it is impossible not to believe that legalizing cocaine for adults would lead to massive increases in the use of cocaine by kids. The effects of those increases on hundreds of thousands of additional young people, and on the children they bear,\textsuperscript{202} are devastating to contemplate.

Proponents of legalization generally ignore the implications of their position for children and adolescents, because they assume that effective age-selective prohibition is possible. Instead, proponents of legalization urge that Americans end the social assault on cocaine abuse in order to reduce drug-related violence and to save money. Law enforcement and fiscal policy are not areas within our special competence. Nevertheless, both of these justifications seem extremely weak. If the battle against cocaine is exacerbating violence, why has the murder rate declined nationally from 1986 to 1987, and presently stands at a level almost 20 percent below that of 1980,

\textsuperscript{199} See Youth Drug Survey, supra note 31, at 56 (finding that 18% of the class of 1988 used marijuana in the past 30 days and 63.9% used alcohol).

\textsuperscript{200} See id. at 57 (finding that 2.7% of the class of 1988 used marijuana daily and 18.1% used cigarettes daily).

\textsuperscript{201} Id. at 54, 56-57. It is easy to imagine how these differences occur, with older siblings or friends buying alcohol for their younger companions, and adults turning a blind eye out of sympathy for what seems to them normal adult behavior or out of guilt over the privileged status that alcohol possesses in our culture.

In part, too, the contrasting usage levels also reflect differences in teenagers' perceptions about the harmfulness of alcohol and cigarettes versus other drugs. Thus, more seniors regard regular use of marijuana as compared to heavy cigarette smoking as seriously harmful, but not by much (77\% versus 68\%). Id. at 129. Experimentation with marijuana or cocaine is considered harmful only by 19\% (marijuana) and 51\% (cocaine) of twelfth graders. Id. Perceptions about harmfulness, moreover, may be substantially influenced by the government's decision to prohibit a substance to all age groups, and the lesser opportunities that result for kids to see adults using it publicly and with positive demeanor.

\textsuperscript{202} See supra notes 125-37 and accompanying text (discussing drugs' effects on adolescents and their offspring).
before the “drug war” began to be fought in earnest? It is less than obvious how permitting cocaine’s widespread use will create a net decrease in violence. Regarding the costs of battling cocaine and taxes foregone that could be collected after legalization, these must be weighed against the bills that will arise in providing long-term care for infants born of users, and the loss of taxes resulting from the employment difficulties of cocaine addicts.

We do not pretend to have full answers to each of the arguments typically advanced in favor of legalization. Yet, we also do not have the answers for the thousands of kids who come to us with life-threatening crack or cocaine addictions. It is clear to us that without criminal sanctions against the traffic in cocaine, the plight of the kids who come to Covenant House and other similar programs would be even worse and their numbers would swell. This makes legalization look not just wrong, but brutally wrong.

B. Additional Strategies

It is equally wrong to embrace the criminal law as if it were by itself sufficient to protect and rescue kids from cocaine. Criminal sanctions in the aggregate will reduce its ravages among the young, by reducing cocaine’s availability. However, unless these measures are reinforced by other anti-cocaine efforts, including major investments in treatment and prevention, its success will be very limited. Furthermore, unless accompanied by renewed interest in preventing all adolescent substance abuse, especially cigarettes and alcohol, it may ultimately unravel. Because these strategies are outside the scope of the Symposium, we only briefly comment on them.

1. Treatment.— To a young person addicted to drugs, nothing is more important than immediate and effective treatment. Unfortunately, no approach to treating cocaine abuse has demonstrated it can accommodate the enormous demand from users for immediate help with a strong probability of success. As one commentator

203.  DEPARTMENT OF JUSTICE SOURCEBOOK, supra note 82, at 446 (table 3.122) (noting that the total number of murders and non-negligent manslaughters were 17,859, 19,257, and 21,860 in 1987, 1986, and 1980 respectively).

204.  See supra notes 144-46 and accompanying text.

205.  See supra notes 133-37 and accompanying text.

206.  See supra note 129 and accompanying text.

recently declared, "there are no clear data to suggest that any one treatment approach is superior or that specific patients should be matched to particular psychotherapies."^209^ It is still unclear how adolescents with very special developmental needs should be treated.^210^ For example, Covenant House has instituted its own treatment effort in response to the paucity of other options for its clients. The Covenant House Addiction Management Program (CHAMP) relies on a combination of individual and group counseling including the "twelve steps" of such groups as Alcoholics Anonymous, and a highly structured but supportive residential setting. Although promising to date, CHAMP remains too young for any clear assessment of its value. What it has taught us beyond any doubt, however, is the overwhelming need for treatment opportunities for adolescents, and the extraordinary difficulty of confronting the demons of cocaine once they have seized a human spirit. Only a long-term concerted effort, with substantial federal, state and local resources, can promise any real hope of creating effective, available treatment for all the kids who will need it.

2. Prevention.— In the otherwise bleak landscape of adolescent cocaine abuse, one highly encouraging development has been the significant decline in cocaine use by the class of 1988, from the 15.2% rate reported from the 1987 class, to 12.1% "lifetime prevalence" in the 1988 class.^211^ Combined with a small but significant increase in the percentage of those viewing cocaine use as involving great risk,^212^ this offers some hope that the enormous federal effort against cocaine, along with pervasively negative media coverage concerning its effects, may finally be making headway in preventing first and regu-
lar use. Although substantial research specifically tied to the prevention of cocaine abuse has not yet emerged, other substance-abuse prevention efforts directed at adolescents have recently demonstrated real promise. In 1989, one study of prevention programs aimed at early adolescents in Kansas City found a reduction in the use of alcohol, cigarettes and marijuana by about a third as against a control group.\textsuperscript{213} Prevention methods, especially with smoking, have become extraordinarily various and sophisticated, ranging from programs focusing on narrow refusal skills\textsuperscript{214} to those designed at curbing substance abuse through increasing general, personal and social competence.\textsuperscript{215} The majority have documented some level of success, although often mixed,\textsuperscript{216} while the most successful have been criticized as too costly and complex to introduce on a broad scale.\textsuperscript{217} Thus, it is not yet possible to focus upon one clear strategy for drug abuse prevention. Furthermore, because cocaine may well appeal to young potential users in ways somewhat different from tobacco, alcohol or marijuana, it will be crucial to experiment with prevention programs to test their effectiveness for deterring cocaine use. In the meantime, enlightened public policy would dictate major ongoing prevention efforts in schools and in the media to consolidate and increase the recent gains in students' resistance to experimenting with cocaine.

\textbf{3. Alcohol and Tobacco Abuse - A Modest Proposal.}— Adults committed to protecting children from exposure to addictive and harmful drugs will not find it easy to linger over reports of preven-


\textsuperscript{215} See Botvin & Wills, \textit{Personal and Social Skills Training: Cognitive-Behavioral Approaches to Substance Abuse Prevention}, in NIDA RESEARCH MONOGRAPH No. 63, supra note 214, at 8, 10-15.

\textsuperscript{216} See Flay, supra note 214, at 92 (reporting the “social learning skills” approach, which is based on developing specific refusal skills, as having successes which are “mixed” and marked by “fragility”).

\textsuperscript{217} See Glasgow & McCaul, \textit{Social And Personal Skills Training Programs for Smoking Prevention: Critique and Directions for Future Research}, in NIDA RESEARCH MONOGRAPH No. 63, supra note 214, at 50, 53-54 (discussing the major successes with broader social competence approaches, but noting the great time, monetary cost, and difficulty in training group leaders to employ such methods).
tion research. Reduction of alcohol use by a third as in the Kansas City study\textsuperscript{218} is impressive, but it is dismaying to encounter that study's stark conclusion that 9\% of seventh and eighth graders had used alcohol in the previous month, even \textit{after} the prevention program.\textsuperscript{219} For cigarettes, the 15\% figures are even grimmer.\textsuperscript{220} This is especially disheartening considering the fact that alcohol is \textit{illegal} for teenagers in every state\textsuperscript{221} and the sale of cigarettes to them is banned in most.\textsuperscript{222} Have these laws lost their force to such an extent that Americans will rejoice when our "prevention" programs have succeeded to the point that "only" two in ten eighth graders, five in ten sophomores, and six in ten seniors have transgressed the prohibitions on alcohol use?\textsuperscript{223}

To concede that alcohol and tobacco use by minors is "really" acceptable disregards the health of the kids at risk and, perhaps worse, shows devastating hypocrisy on the whole subject of substance abuse by the young. There is no serious dispute about the health risks of adolescent drinking and smoking, nor about the role those behaviors play as the "gateway" to hard drug use.\textsuperscript{224} Rather, what seems hard for us to face is the moral ambivalence at the heart of our decision to outlaw most addictive, harmful drugs, while maintaining at least marginal acceptance of cigarettes and alcohol. In principle, most Americans seem to agree that the law ought to prevent minors from having access to nicotine and alcohol, but feel too guilty in the midst of our own indulgence in these drugs to enforce the prohibitions in place.

It is precisely the confrontation of our responsibility to the young that those who oppose legalization and those who support it can begin to make common ground, if only to avoid appearing utterly foolish. How is it seriously possible to advocate denying a

\textsuperscript{218} See supra note 213 and accompanying text.

\textsuperscript{219} This figure was compared to the 12\% figure of the group that did not receive treatment. Pentz, Dwyer, MacKinnon, Flay, Hansen, Wang & Johnson, supra note 213, at 3264.

\textsuperscript{220} This figure was compared to the 22\% figure of the control group. Id.


\textsuperscript{223} These proportions represent the 1988 incidence for alcohol use at those grade levels, see \textsc{Youth Drug Survey}, supra note 31, at 94, \textit{reduced} by one-third in accordance with the results of the Pentz study, see supra text accompanying note 218.

\textsuperscript{224} See, e.g., Czechowicz, supra note 131, at 191-194.
thirty-year-old individual access to one or two marijuana cigarettes, while winking at a twelve-year-old getting drunk several times a week? It is equally absurd to argue for the recreational drug rights of thirty-year-olds, when in practice that will mean exposing hundreds of thousands more children to crack.

If prohibition or legalization proponents are to find solid moral turf, both must discover a way to shield minors from access to addictive and harmful drugs, and to shelter children from the effects of their parents' addictions. We, therefore, advance the following modest proposal: that the debate on legalizing hard drugs, and especially cocaine, be tabled until an effective assault is developed on the abuse of alcohol and cigarettes by minors. The assault should encompass both civil and criminal laws and should be supported, at least in part, through diversion of funds now expended to fight adult hard-drug use. Deterring and dissuading teenage substance abuse is, in the short and the long term, a far more cost-effective strategy than trying to overcome the ravages of a lifetime of addiction. If society can pass that test and demonstrate the resolve and the ability to protect the young from harmful drugs, then perhaps we as a society will have earned the right to consider greater liberality in the controls we impose on adult behavior.

IV. FINAL MISGIVINGS ABOUT LEGALIZATION

The shrillness of the debate over legalization does not, however, give us much reason to hope that our effort to find common ground for the combatants will be noticed. Children did not figure much either way in the great debates over Prohibition of the late 1920's and 1930's, and the current battle over cocaine legalization also bids fair to ignore the concerns of children. This is a shame, for children of all Americans have the most to lose from policy mistakes in this area.

We would be less than candid, however, if we did not confess to a final set of misgivings about the merits of drug legalization, misgivings which are not strictly tied to the welfare of the young. Rather, they concern a social contract, a covenant among Americans of all ages, backgrounds and beliefs. We see in the case for legalization
tion of cocaine and other hard drugs troubling glimmers of an effort to break this compact beyond repair.

The possibility of such an effort seems most apparent when the terms of legalization are described concretely, as they were in a recent column by Mike Royko urging an end to the war on drugs:

Let’s call off the war and make the best of the peace. We can view drugs the way we view liquor. . . . If you want to become a lush, that’s a problem for you, your liver and your family. . . . It is this society’s position that if you choose to be a falling-down drunken bum and wind up in the gutter, that is your right. So if you want to sniff or snort or puff your way into the gutter, that should be your right, too.226

Liquor, he continues, “can be a terrible curse for some people, but for most it isn’t.”227 Balancing the costs and benefits of a continued assault on drugs, he concludes that “[i]t’s a lot easier to sweep up gutters than to fight a hopeless war.”228

The “right” to be destitute and outcast strikes a suspiciously familiar note. Is this the newest version of the “right of contract” that the Supreme Court held to preclude state regulation of working conditions in *Lochner v. New York*?229 Are Americans no longer to cause inconvenience or expense to “most people”—as we did, say, in the Social Security Act of 1935230—in order to help those “some people” in our midst who have not found the means to sustain themselves? How deep and how wide are we prepared to dig our gutters?

A facile amendment to this vision—that Americans will continue to provide basic care for the desperately needy, whether addicts or not—somehow rings false. Unlimited availability of cocaine would, as Mr. Royko foresees, send vast new armies of Americans into self-chosen poverty.231 Already the streets of many cities are bursting with the homeless, most of whom are there at least partly as a consequence of alcohol or drug abuse.232 Their addictions, espe-

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226. Royko, supra note 191, at 3H, col. 4.
227. Id.
228. Id.
229. 198 U.S. 45, 64 (1905) (stating that “the freedom of master and employ[ee] to contract with each other in relation to their employment, and in defining the same, cannot be prohibited or interfered with without violating the Federal Constitution.”).
231. This is the predictable result of cocaine’s ability to supplant normal instincts of self-preservation. See supra notes 141-50 and accompanying text.
cially when they involve the violent potential of cocaine, can make helping them off the street seem impossible.\textsuperscript{233} Without proven, cheap treatments for cocaine addiction, it is indeed a wrenching, frustrating task trying to determine whether and how to help them. Legalization would “solve” all of this for us, we suspect, by first seducing us into believing that addicts can and will take care of themselves and then by proving, this time without any chance of refutation, that trying to help them out of their destitution is far too great a task for our limited resources.

We can understand the appeal of this scenario to those who have remained in the dissent from the social compacts established in the New Deal, and who fundamentally oppose the idea of a welfare state that seeks to preserve all citizens from utter degradation and want. It was, after all, the opposition of large business groups that doomed Prohibition.\textsuperscript{234} Continued prohibition of cocaine from this perspective can simply appear another irrational governmental restriction on market freedom, and a particularly expensive one.

For those individuals and entities who \textit{do} wish to adhere to those compacts, however, legalization can only signal a course of despair and defeat. Since the Roosevelt era, middle class citizens have been persuaded to help those whose lives have been derailed by large economic or cultural forces, including both alcohol and tobacco, which have been long accepted in our society. They will not abide, however, continually escalating demands to support lifestyles shaped by new and even deadlier drugs. Eventually the New Deal’s electoral foundations will give way.

It may make us uncomfortable to realize that a certain quantity of social control is essential to the maintenance of a democratic consensus supporting social welfare efforts by the government. Accustomed to thinking about “rights” and “entitlements” in the context of poverty, we are not comfortable with the notions of a binding relationship that social control implies. Nor are we able to easily contemplate making “moral” choices for others, even in such relatively straightforward matters as adolescent cocaine abuse.

\textsuperscript{233} See Kolata, supra note 232, at A13, col. 1 (stating that one operator of single-room-occupancy housing declared crack makes the homeless “aggressive and violent” so that “we can’t house [them] because of behavior problems.”).

\textsuperscript{234} See Aaron & Musto, supra note 12, at 166-69.
Unfortunately, it is not possible to avoid such choices if nurturing social relationships are to be preserved. Just as destruction of others can end one's right to participate in the social compact, so too, in the extreme case, can self-destructive acts indirectly harm and burden others. Cocaine is the extreme case, and to legalize it would bring the American social compact to a premature death after barely 50 years of life.

V. Conclusion

Cocaine is stalking the young of this country—on the street, in the home, and in their mothers' wombs. Those whom addiction strikes are frequently devoured whole, losing family, innocence, sanity and even their lives along the way. Among all the forces putting them at risk, one stands far above the rest in power—the availability of the drug.

Rational public policy must recognize the crucial role availability plays in adolescent cocaine abuse and the apparent impossibility of protecting kids while allowing adults to indulge themselves in the drug. Maintenance of criminal sanctions against cocaine traffic, combined with renewed prevention and treatment efforts will, at least, provide an ongoing defense against the further advance of cocaine use among the young. A vigorous campaign against teenage abuse of alcohol and tobacco could seriously weaken the threat of cocaine abuse and, if successful, might lead to common ground for discussion of relaxing restrictions on adult access to cocaine.

The welfare of children ought to be our dearest concern in matters such as the shaping of drug policy, but this is not always easy to remember. We ought to be able to recognize and avoid those concessions to individual liberty that would make a humane society impossible to achieve, but from time to time we forget. Perhaps we falter because we fail to accept wholeheartedly what Coleridge knew even in his blackest nights of addiction: "That I am weak, yet not unblest, / Since in me, round me, every where / Eternal Strength and Wisdom are."  

235. See supra notes 164-83 and accompanying text.
236. See supra notes 184-217 and accompanying text.
237. Coleridge, supra note 2, at 435.