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NATIONAL INSTITUTE OF JUSTICE

Research in Brief

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The Rise of Crack and Ice: Experiences in Three Locales

by Marcia R. Chaiken

In the mid-1980's, drug traffickers and street dealers saw an opportunity to boost their profits by marketing new products to existing and new customers. "Crack," a cheaper, smokable form of cocaine, flooded the market in many cities. And "ice," crystal methamphetamine in smokable form, was sold on the island of Oahu, Hawaii.

By 1986, local officials and criminal justice professionals in these areas realized that they now had a very serious problem. By the time the dimensions of crack use were recognized, however, it had reached epidemic proportions. In the case of ice, on the other hand, the emerging pattern of use was recognized earlier, making possible some effective actions to curb its spread.

To help local officials anticipate and head off drug epidemics, the National Institute of Justice commissioned a project to review what happened in local communities when these old drugs emerged in new forms. The project developed case studies of north Manhattan, south central Los Angeles and adjacent communities, and Oahu, Hawaii. This article summarizes the project's findings.¹

Timing is critical

The one factor in prevention that clearly emerges from experiences at the three study sites is timing. Epidemics do not occur spontaneously; they are the result of many activities and influences. Identifying the use of a new drug in an early stage may stop its spread, while ignoring symptoms may lead to uncontrolled growth. For example, the study found that:

- The spread in popularity of smokable base cocaine and smokable crystal methamphetamine occurred for years before drawing any substantial attention from the news media.
- Although local researchers and professionals had available numerous indicators of the emerging problems, the information was not pulled together early enough to give a clear picture of what was happening.
- The increase in use and sales of smokable cocaine—crack in Manhattan and "rock" in Los Angeles—was identified too late for public agencies to respond

effectively and prevent a devastating ongoing epidemic.

- On Oahu, where marketing of ice (smokable crystal methamphetamine) was identified early, coordinated law enforcement, prevention, and treatment efforts interrupted a trend toward wider use of crystal methamphetamine.

Early recognition of emerging drug patterns is possible and can lead to successful strategies for countering drug abuse. This *Research in Brief* reviews ideas grounded in the experiences of a broad range of criminal justice professionals and researchers who were working in the study sites as the epidemics developed. The lessons they learned the hard way may help other communities facing similar epidemics.

Information was gathered from local researchers, criminal justice agency staff, treatment personnel, and others who had been in frequent contact with drug users and dealers when the smoking of base cocaine or crystal methamphetamine began to increase. Newspaper stories about these substances were also searched

Understanding how a specific drug begins to take hold and then proliferates within various segments of the society can help law enforcement officials recognize new patterns of drug use and plan effective responses.

The National Institute of Justice (NIJ) is mandated by the Congress to conduct research and development projects to curb and prevent drug abuse and crime and to

inform the justice community of policies and strategies that work in crime control.

This NIJ *Research in Brief* outlines a useful approach to identifying and curtail-ing new types of drug use before they grow to epidemic proportions. The research, based on case studies of the emergence and spread of crack in Manhattan and Los Angeles and the introduction of "ice" in Hawaii, shows that frequent community monitoring, coupled with cooperation

among law enforcement agencies, has the potential to break up drug markets before they are fully established.

As this *Brief* documents, early recognition of emerging drug patterns is possible and is a vital component in the development of strategies to counter drug abuse. This *Brief* focuses on ways in which local officials and agencies can combine their efforts to stem drug epidemics in their communities.

National Institute of Justice

and reviewed. Epidemiologists and other researchers in State and Federal agencies supplied valuable information about trends in cocaine and crystal methamphetamine use in the study sites.

The following picture emerges on the rise of crack cocaine in north Manhattan, rock in south central Los Angeles, and ice on the island of Oahu.

How crack and rock spread in Manhattan and Los Angeles

Manhattan and Los Angeles were selected for this study because they experienced high levels of use and distribution of crack or rock (smokable base cocaine). Furthermore, they were among the first places where base smoking became popular. These locales provided an opportunity to explore how this form of drug abuse intensified, who knew about it, and what actions were taken in response.

Newspaper reports about increased smoking of crack in Manhattan and rock in Los Angeles did not appear until late 1985, more than 5 years after smoking base cocaine had already become popular among specific groups in north Manhattan and south central Los Angeles. In both of these places, use of the former drugs of preference—such as heroin and PCP—began to decline in 1980, coinciding with the growing popularity of cocaine smoking at neighborhood parties and social clubs. In south central Los Angeles, simple recipes that made use of baking soda for rocking up cocaine (converting the acid powdered inhalant form to smokable base) circulated at parties. The method was spread to adjacent areas by drug dealers who had observed the process.

By 1983, neighborhood drug dealers saw an opportunity to enhance their profits by marketing cocaine pre-prepared in a smokable form. By 1984, competition led to new marketing strategies. Some dealers sold base or rock in small, more affordable amounts. They gave the substance catchy names like "crack." Between 1984 and 1985, base use rose precipitously, overwhelming municipal and county agencies. Police developed new tactics to close down street and indoor markets for crack or rock. More than 6 years later, after many efforts by law enforcement and other agencies, cocaine use appeared to have

somewhat declined in the study sites. However, cocaine smoking was still considered to be a serious problem.

How ice threatened Oahu

Oahu was chosen for the study because the island was experiencing a different local pattern of substance abuse, one that was spreading very rapidly, namely smoking of ice (smokable crystal methamphetamine).

Although smoking crystal methamphetamine did not make the front pages of Oahu's newspapers until 1988, one form known as batu had emerged among certain of the island's ethnic groups in particular communities before 1980. During the early 1980's, cocaine smoking became popular, although most resident drug users preferred or could only afford to use pakkalo (Hawaiian-grown marijuana). At the same time, batu smoking also increased, especially among industrious immigrants from the Far East who used the substance to stay awake while working both day and night. A shortage of pakkalo about 1985 may have contributed to the popularity of smoking batu. As with base smoking in Manhattan and Los Angeles, smokable crystal methamphetamine preparations were originally home cooked, and the initial spread of recipes was primarily through overlapping social circles.

Enterprising drug dealers on Oahu, realizing that potentially large sums could be made by marketing prepared smokable crystal methamphetamine, developed the term ice. Although more costly per hit than base cocaine, smokable methamphetamine was nonetheless touted as a relatively inexpensive, pure, hard-to-detect, reusable drug that produced better and longer highs than cocaine.

In 1986, the Honolulu police began to investigate the drug and its use. Within months, police cooperated with other criminal justice agencies and with health practitioners, educators, and other professionals in spreading the word that ice use was a harmful practice. During 1987 and 1988, many agencies made comprehensive, coordinated efforts to curtail methamphetamine smoking and sales.

By 1989, organized ice dealing appeared to have been generally suppressed, and use

was dropping rapidly on Oahu. In the years since, law enforcement, treatment, and drug prevention agencies have continued to closely monitor indicators of ice availability and to focus on areas and populations where smokable methamphetamine continues to be distributed and used.

Although on Oahu some hard-to-reach drug users still smoke ice, the strategy implemented in the late 1980's was followed by an immediate and remarkable decrease in supply and demand for ice. Despite a slight rebound in the ice supply in the early 1990's, sales and use of ice appear to have remained at a much lower level than before the concerted effort.²

Stages in the development of drug use patterns

Some common elements, or stages, in the development of new drugs or drug forms can be pinpointed. Being able to identify these stages can help local officials understand better what the immediate problem is and develop ways to forestall the next likely events in a drug's developing use.

Stage 1. Use is confined to small, isolated communities or subcultures. This is the lowest level of use to which a drug can realistically be kept, even when the substance has been publicly condemned. Use of cocaine in the study sites in the early to mid-1970's was confined primarily to relatively well-to-do groups in the entertainment industries.

In the same locales, endemic methamphetamine use was confined primarily to remnants of groups that had been users during previous periods of the drug's popularity (see "Origins of Cocaine and Methamphetamine Use" on next page). In Los Angeles and New York, a few speed-freaks continued to use crystal methamphetamine. On Oahu, use was primarily confined to aging hippies and to immigrants from Asian countries where methamphetamine use had continued since the 1940's.

Stage 2: Users switch to various types of drugs or preparations. Users of one drug often experiment with another drug that is in endemic use close by, sometimes to replace drugs that are no longer appealing or accessible. Various forms of preparations and modes of administration of a number of substances may be tried.

Origins of Cocaine and Methamphetamine Use

Although their use has spread alarmingly in recent years, both cocaine and methamphetamine had earlier heydays when they were popular.

Cocaine. In the beginning of the 20th century, coca products were used by many people in the form of tonics, wines, and teas. The benefits of coca products were extolled publicly until early in the 1920's, when laws were passed prohibiting the manufacture and distribution of coca products and alcoholic beverages. Even though prohibition was effective in suppressing coca use, coca products continued to be used by relatively small numbers of people who belonged to specific subcultures.

For most of the 1970's, the decade before the years described in this report, cocaine use in the study sites was confined primarily to people in the entertainment industry—actors and musicians in New York night clubs, the Los Angeles film industry, and the Hawaii tourist trade. Although periodically cocaine was used in combination with other drugs and occasionally smoked in its base form, most users snorted acid cocaine preparations.

Methamphetamine. In its last previous incarnation, when it was called speed, methamphetamine was popular among flower-children, bikers, and other counter-culture groups of the 1960's. The drug received widespread public recognition as a dangerous substance, in part through public health announcements that speed kills.

In Manhattan, for instance, opiates, especially heroin, were the drugs of preference in the 1970's. The disastrous consequences of heroin use—addicted babies, increased crime rates as the most severely addicted users turned to theft, burglary, and violent robbery—caused public opinion to give a high priority to treating heroin addicts and arresting dope dealers. Oahu escaped the heroin epidemic, but the rich diversity of ethnic groups that had immigrated to the island or visited as tourists brought with them a mix of drugs that began to

rival marijuana in popularity in some areas. Caucasians brought powder and base cocaine, and Filipinos brought batu, a relatively pure form of crystal methamphetamine.

Stage 3: Local opinion coalesces around a specific drug preparation. Frequent users of drugs discuss and justify to themselves the selection of a particular substance. By 1980 cocaine emerged as a favored drug in all three study sites. In the inner city in Los Angeles and in north Manhattan, the base form of cocaine rapidly gained popularity. Local lore, a mixture of fact and fantasy, touted base as being less harmful than the acid form. It was said to induce euphoria without unpleasant side effects.

On Oahu, the drug was popular among Caucasians, but among groups like the Filipinos, who traditionally did not use drugs, neither the acid nor the base form of cocaine became popular. Yet recent immigrants from the Philippines, who had to work day and night to support their families, found smoking batu was a way to stay alert. A pipe of batu had no strong odor when smoked and could be repeatedly heated and cooled down. Word of batu's advantages spread to Hawaiians and others, including young Caucasian women who were told that batu contributed to weight loss.

Stage 4: Distribution by enterprising drug dealers accelerates. The organization of local drug dealerships reflects typical free enterprise patterns in many ways. People who seek to move rapidly up the economic ladder but reject legitimate methods are the most likely participants, as are marginally employed residents of the drug-using communities.

In Los Angeles and Manhattan, the first dealerships were respectively called rock houses or base houses. Such organized houses did not appear on Oahu, perhaps because there were too few users to support this form of enterprise in the early 1980's. By the time the demand was high enough to make a base house economical, the Honolulu police were on the lookout for such houses; they apparently shut down the few that were formed.

Stage 5: Drug use increases precipitously. Typically, sharp increase in use is propelled by ready availability, low cost, and a widespread notion that the substance

is desirable. Stories about the drug spread, and as demand increases, more suppliers are drawn into the market.

Both in Los Angeles and Manhattan, the number of users rose sharply between 1983 and 1984, about a year before the term "crack" was coined. Dealers recruited youngsters to help them meet the increasing demand. Intensive competition led to innovative marketing. Vials for peddling small amounts became commonplace on the East Coast, with prices dropping to \$10 for the smallest vial. Even smaller vials, midgets, were produced, and prices dropped to \$5. On the West Coast, small ziplock bags were used for small amounts of rock or base.

Precipitous increases in crystal methamphetamine smoking on Oahu occurred between 1985 and 1986. The term "ice" was not used until the substance was relatively widespread among particular groups, including Filipino girls who were not usually substance abusers and Caucasian and Hawaiian youngsters who had been using marijuana until a crop destruction program reduced the supply.

Stage 6: Drug use reaches epidemic proportions and overloads public agencies and health systems. The number of new users spirals upward, and existing users raise their consumption of the drug. If the drug is physically addictive, emergency rooms and other health services are overwhelmed by users and infants born to addicted mothers. Drugs that produce psychotic or violent episodes overload psychiatric and other emergency facilities with users and victims. Addicted family members neglect children or others in need of care. Rises in crime to support drug habits strain police and other criminal justice resources.

Stage 7: The media report on the drug. Articles in newspapers call attention to the drug problem. Given their emphasis on news, media stories may implicitly or explicitly suggest that the drug is new. Even in the late 1980's, articles on crack and ice created the impression that these were new drugs even though base cocaine and rock had been around for a decade in Los Angeles. By using a different term—crack—the stories seemed to make the drug more desirable to youngsters who wanted to impress their peers. Although media reports about the dangers of ice

deterred some potential users on the mainland, for others the stories made the drug more alluring.

The stages described above represent worst cases. Fortunately, many drugs do not make it past early stages. Stage 1, endemic use, can last for decades, and progression to an advanced stage does not necessarily presage an eventual epidemic.

Issues in getting and using information

To be useful for monitoring the increasing popularity of a substance, available information needs to be collected, consolidated, and analyzed. Several issues are integral to obtaining and using necessary information.

No single source of information appears adequate for monitoring the increasing popularity of an illegal substance. Any given source of information is limited because it focuses on a particular population. For example, information from outreach workers applies only to the people with whom they come in contact. To get a comprehensive view, one must assemble information from a range of outreach workers who serve different groups. The same is true for survey information, which must be obtained not just from households and schools but also from transients and dropouts, and not just from English-speaking residents but also from immigrants who speak only their native language.

Moreover, some information sources focus only on certain processes—grassroot forms of drug distribution, or organized economic activities, or system responses to drug activities. When used alone, this kind of information may give a distorted view of what is really happening. Arrest data provide an example. In the study sites, during street-level crackdowns on cocaine sales, the number of arrests for cocaine understandably soared. Yet at the same time, emergency rooms in the same area reported fewer cases involving cocaine.³

While some sources of information can shed light on early stages of developing patterns, others apply at later stages. Figure 1 presents various sources of useful information as they became available in the study sites at each development stage.

The information available may not be in a readily usable form. Agencies gather

Figure 1. Sources of Information by Stage of Development

Stage 1: Isolated Endemic Use

Anthropologists
Ethnographers
Outreach workers/field case workers

Stage 2: Initial Grassroots Switches in Drugs Used

Previous resources plus:
Street research teams
Individual police community patrol officers/narcotics officers

Stage 3: Local Coalescence of Opinion About the Drug and Spread in Use

Previous resources plus:
Local drug treatment counselors/hotline staff
Local medical staff (psychiatric/obstetrics if women users)
School counselors
School-based prevention program staff

Stage 4: Accelerated Grassroots Distribution by Drug Dealers

Previous resources plus:
Police personnel—local complaints/calls for service
Narcotics units
Police laboratory statistics
Criminal justice system population urinalysis statistics

Stage 5: Precipitous Increases in Use

Previous resources plus:
Local surveys of treatment admissions
Local medical examiner/DAWN statistics
Local self-report surveys (school, household, criminal justice populations)

Stage 6: Epidemic Use and System Overload

Previous resources plus:
Administrators in health/mental health/law enforcement agencies

information for their own purposes. Typically the information is recorded in a format that allows a quick review of a particular case but not a comprehensive review across cases. Compiling information across cases can be both burdensome and expensive and usually will not be done unless there is an urgent need. In the study sites by 1990, many agencies had assigned staff to collect drug use data across cases, and a small number of them were designing and implementing computer systems to enhance data collection. However, all this occurred for the most part after base cocaine and crystal methamphetamine smoking had already reached epidemic proportions.

Agencies are not likely to coordinate information unless one organization takes the

lead and actively, continuously pursues information. Lack of coordination of information from multiple sources appeared to prevent noticing the increasing popularity of smokable cocaine and methamphetamine early enough to stop the epidemic. With the exception of information about crystal methamphetamine use on Oahu, useful data were rarely shared across agencies or even within a single agency.

Criminal justice professionals and researchers have compelling reasons not to release raw numbers to outside agencies. They wish to ensure the confidentiality, quality, and statistical reliability of their data and so delay releasing data until established procedures have been followed. Some obstacles could be circumvented by common cross-agency

agreements to modify or abandon some procedures in the interest of a rapid, coordinated response.

Sources and types of information

Anthropological and ethnographic information. Researchers who conduct ethnographic or anthropological studies in a given community appear to have the earliest and most detailed information about specific types of substances used by particular groups. They can show shifts in use and describe common lore about specific drugs. The information is not only fruitful for identifying drug use patterns but also for understanding the motivations and attitudes of groups using specific substances.

Street information. In New York City, the State Division of Substance Abuse Services has formed small teams of streetwise personnel to gather information about drug use and drug sales in public places. Since the mid-1970's, teams have observed designated neighborhoods to discover the types of drugs being sold on specific blocks. The street-team members meet weekly to be debriefed by their supervisor. In late 1983, the term "crack" was first used at a debriefing.

Many street terms are used interchangeably. For example, cocaine can be called crack, rock, coke, base, snow, nose candy, blow, power, toot, and white Christmas. Other terms reflect changes in drugs used, groups using the drug, or methods of marketing or distribution.

Information like this can be obtained by listening to street talk—a mixture of fact, fantasy, and conjecture on the part of drug users and dealers, their families, and close neighbors. To be at all useful, street information must be analyzed and consistent patterns determined.

Practical information from outreach workers and drug treatment counselors. To carry out their jobs, outreach workers, caseworkers, school nurses and counselors, and drug treatment counselors must obtain detailed information from the people they serve. They, too, obtain important information from street talk.

Although they were not especially looking for new forms of illegal substances in use, these professionals in inner city areas

were aware of the increasing popularity of smokable cocaine as early as 1980. They knew about simple recipes for preparing base cocaine in Los Angeles in 1980 and in New York in 1982. On Oahu, outreach workers in some of the most impoverished communities became aware of batu in 1983.

Only in retrospect did these professionals realize the importance of the information they had about cocaine and methamphetamine smoking in the early 1980's. In the future, however, researchers may be able to obtain practical information from outreach workers, drug counselors, and other professionals early enough to analyze emerging patterns of use.

Physical symptoms and medical evidence. Although not widely reported until cocaine and methamphetamine smoking had reached epidemic proportions, shifts in the physical symptoms of drug users and results of laboratory tests of their bodily fluids provided early evidence of new patterns of use in the study sites. Case histories of clients, plus urinalysis and blood tests, confirmed cocaine and methamphetamine as the underlying cause of changes in medical symptoms, including some deaths.

Local law enforcement information. In retrospect, law enforcement agencies in all three study sites received numerous early indicators of the growing use of smokable cocaine and, on Oahu, of smokable methamphetamine. But the information was random and fragmentary. Indicators that might have been used to identify patterns of smoking cocaine and methamphetamine include (1) community complaints and other grassroots information, (2) changes in confiscated drug paraphernalia, (3) arrests and seizures involving specific substances, and (4) information about arrestees and modes of distribution.

Survey information. Several Federal agencies carry out systematic methods for monitoring national trends in drug abuse. Most notable are the National Household Survey on Drug Abuse,⁴ the National Survey of High School Seniors,⁵ the Drug Abuse Warning Network,⁶ the Community Epidemiology Work Group of the National Institute on Drug Abuse,⁷ and the National Institute of Justice's Drug Use Forecasting Program.⁸ However, local officials need to interpret national trends with caution be-

cause of large differences in patterns of use among regions and cities.

State and local survey information tends to be underutilized by agencies other than those directly responsible for collecting information. Several types of data could be shared among agencies, however, including results of urine tests for drug use among arrestees, self-report information on students' use of specific drugs, and data obtained from people who enter treatment programs.

Media reports. News stories are among the least timely sources of information and sometimes present a distorted view of the problem because of emphasis on the new or the dramatic. Fortunately, however, there are reporters who seek out and write accurate information. Their stories perform an important role in telling the public as well as public officials about health hazards of specific substances.

Working together

The case studies show the need to act cooperatively at an early stage in a drug's rise in popularity, first to gather and analyze interdisciplinary information and then to implement drug reduction strategies.

Cooperative efforts among local agencies in north Manhattan and central Los Angeles were mostly limited to sharing information about crack and incorporating it in primary prevention programs jointly implemented by law enforcement agencies and school administrations.

On Oahu, the incipient epidemic was recognized at an earlier stage than in Los Angeles and New York. Professionals in a range of agencies cooperated in carrying out a comprehensive strategy that encompassed virtually all of the tactics presented in the 1991 National Drug Control Strategy (see box on next page). The following are among some of the actions taken on the island after authorities identified the ice threat:

- Police, educators, treatment staff, and Federal agencies on Oahu maintained frequent contact to identify and curtail aggressive marketing and use of base cocaine. By the time ice began to grow in popularity, officials were already on the lookout and ready.

- Police investigating a murder discovered that drug crew members were dealing

The National Drug Control Strategy's Comprehensive Approach

The 1991 National Drug Control Strategy⁹ recommends a comprehensive approach to combating drugs including the following measures:

- Taking actions to prevent people from using drugs in the first place.
- Providing effective treatment for those who need it and benefit from it.
- Holding users accountable for their actions and thereby deterring others from using drugs.
- Prosecuting dealers and traffickers.
- Punishing those convicted of drug crimes.
- Disrupting the flow of drugs, drug money, and related chemicals.
- Engaging other nations in efforts to reduce growth, production, and distribution of drugs.
- Supporting basic and applied research in behavior, medicine, and technology.
- Improving intelligence capabilities in order to attack drug trafficking organizations more effectively.

In sum, the 1991 strategy states, "No single tactic by itself is sufficient. All of these must be employed."

in ice. They followed up on the information and discovered more about the substance and its source. The potential problem of ice was identified just as distribution became organized.

- Police coordinated efforts to learn about local ice use. Narcotics officers worked with parents, teachers, officers involved in prevention programs, and treatment staff to gain and pass on information.
- The U.S. Attorney and the Honolulu Police Department, in cooperation with the Hawaii Department of Education, Department of Health, and private associations, organized prevention programs such as the Coalition for a Drug-Free Hawaii.
- The Honolulu police formed a "crystal ball" task force in cooperation with

Federal agencies and narcotics officers in several Asian countries to trace the networks importing crystal methamphetamine into the country.

- A variety of agencies worked together to identify juvenile and adult users and provide effective treatment. They worked with school counselors and established a crystal/cocaine hotline.
- Researchers at the National Institute on Drug Abuse were invited to conduct a field investigation and to suggest better methods to monitor drug patterns. Their recommendations led to the establishment of a Hawaii State Epidemiology Work Group, more consistent entry and analysis of data about drugs used by treatment program clients before admission, and wider distribution of survey results on drug use.

How to identify and respond to drug use changes

Ideas on how to identify and respond to local changes in forms of drug use are based on advice provided by researchers and policymakers in Federal agencies; opinions of professionals and researchers in Manhattan, Los Angeles, and Oahu; and findings of the case studies themselves. Basically, almost all agreed on these measures:

- Form a coalition of professionals and researchers to meet and exchange relevant information regularly on any drug gaining local popularity.
- Find as many facts as possible about the properties of the drug, the method of distribution, and the appeal to users before taking action.
- Publicize factual information about symptoms of a drug's use and its health hazards to discourage initial use. Target publicity especially at groups most likely to find the drug appealing.
- Be alert to initial indicators of drug marketing and act rapidly to disrupt organizations simultaneously at all levels of dealing.
- Mount a coordinated effort to identify frequent users and provide effective intervention.

The experiences recounted in this *Research in Brief* urge officials and community leaders to implement such activities

before a new problem crops up in their area and to get the entire community involved. Some specific questions they will need to address at the outset are presented in the box on the next page.

Basically, the increasing popularity of a drug reflects many factors including community attitudes toward the use of harmful substances in general. Clamping down on one drug is likely to lead to increased use of another unless the community as a whole coordinates efforts to reduce all forms of substance abuse.

One final consideration. Communities should keep on their guard. Once use has reached an epidemic stage, decreases simply indicate progress, not a solution. A community that disbands its monitoring and prevention programs risks being overwhelmed by a drug epidemic once more, before having noticed that a new cycle of substance abuse has begun.

Notes

1. Observations reported in this *Research in Brief* were conveyed by officials, researchers, and other professionals who were working during this time period in the sites studied. Quantitative data were provided by numerous agencies and researchers. They are acknowledged individually in the full report that provides the basis for this *Research in Brief*. See author's box.

2. Wood, D. William, and Christina Carlson. 1991. "Trends of Illicit Drug Use in Honolulu, Hawaii," in *Community Epidemiology Work Group Proceedings*. Rockville, Maryland: National Institute on Drug Abuse, pp. 122-138.

3. For a detailed discussion of problems with using police records for studying drug use, see Ryan, Patrick J., Paul Goldstein, Henry H. Brownstein, and Patricia A. Belluci. 1990. "Who's Right: Different Outcomes When Police and Scientists View the Same Set of Homicide Events, New York City, 1988," in Mario DelaRosa, Elizabeth Y. Lambert, and Bernard Gropper, eds., *NIDA Research Monograph 103: Drugs and Violence: Causes, Correlates and Consequences*. Rockville, Maryland: National Institute on Drug Abuse, pp. 239-263.

4. See for example National Institute on Drug Abuse. 1985. *NIDA Capsules: National Household Survey on Drug Abuse*. Rockville, Maryland: Department of Health and Human Services. See also Cox, Brenda, and Sara C. Wheelless. 1988. *Sample Design Plan for the 1988 National Household Survey on Drug Abuse*. (RTI/4181/03-011). Research Triangle

Some Key Issues

A variety of questions need to be addressed before a community implements the approaches suggested by the National Drug Control Strategy. A few are presented below, accompanied by suggestions from professionals who learned from the rise of crack, rock, and ice in the three study sites.

1. The recommended strategy suggests the formation of a coalition for monitoring local drug abuse patterns. Who should be involved?

The following should be involved: participating professionals from a spectrum of law enforcement, health, treatment, and education agencies dealing with a variety of populations, especially populations at high risk of experimenting with new drugs, staff from locally based Federal agencies, and researchers who collect and analyze local information about drug use.

2. If drug use patterns are often in flux, how can coalition participants decide when and if minor changes really indicate an emerging epidemic?

When two or more individual reports indicate a specific change in drugs used (or a specific change in methods of administering drugs), it is a signal to ask researchers trained in epidemiologic methods to conduct a field investigation.

3. How receptive are "hands-on" professionals to participating in such a coalition?

If their participation is recognized as important, if meetings and materials are kept as short as possible, and if interactions are informative, receptiveness will probably not be an issue. However, the coalition members will have to develop common vocabularies and avoid turf issues.

4. Should action be taken as soon as a new pattern of increasing use is discovered?

Yes, but first find out as much as possible about the drug, and then feed facts about specific hazards to users through outreach workers, counselors, or other professionals.

5. Once a new pattern is discovered, what sources are available for learning more about the symptoms and longer term effects of using the drug?

In addition to information available from the National Institute of Justice, summaries and compilations of recent literature are available through various Federal agencies such as the National Institute on Drug Abuse and the Drug Enforcement Administration. (See list of publications and information sources at the end of this *Research in Brief*.)

6. Other than conducting routine law enforcement activities, what role can local law enforcement agencies play in responding to increasing popularization of a particular drug?

They can play a central role in coordinating efforts to identify a drug's increasing popularity and carrying out a cross-agency, cooperative response. The Honolulu Police Department and the U.S. Attorney on Oahu coordinated efforts between and within agencies to learn about local use of the particular drug; made national and international contacts to learn more about the drug; shared information with educators, health practitioners, and professionals in other agencies; and helped form a coalition to prevent substance abuse. They formed interagency task forces to concentrate on disrupting dealing at every level of distribution and providing alternatives to youngsters at high risk of being recruited into sales. They obtained the cooperation of all criminal justice system agencies in providing swift punishment and severe consequences for selling methamphetamine.

7. What steps are needed to identify users more quickly and provide more effective intervention?

Criminal justice professionals, family members, and others in contact with high-risk populations need to be given explicit details about symptoms users display while under the effect of the drug and during withdrawal. They also need to have a direct and simple way to contact drug abuse counselors, outreach workers, case managers, or other professionals trained in intervention techniques. Hotlines seem to be a good way of providing this service.

Park, North Carolina: Research Triangle Institute.

5. See for example Johnston, Lloyd D., Patrick M. O'Malley, and Jerald G. Bachman. 1986. *Drug Use Among American High School Students, College Students, and Other Young Adults, National Trends Through 1985*. Rockville, Maryland: National Institute on Drug Abuse. Also Johnston, Lloyd D., Patrick M. O'Malley, and Jerald G. Bachman. 1985. *Use of Licit and Illicit Drugs by America's High School Students, 1975-1984*. Rockville, Maryland: National Institute on Drug Abuse.

6. See for example National Institute on Drug Abuse. 1987. *Statistical Series Trends in Drug Abuse Related Hospital Emergency Room Episodes and Medical Examiner Cases for Selected Drugs DAWN 1976-1985: Topical Data From the Drug Abuse Warning Network (DAWN)*, Series H, No. 3. Rockville, Maryland: U.S. Department of Health and Human Services.

7. See for example National Institute on Drug Abuse. 1986. *Drug Abuse Trends and Research Issues: Community Epidemiology Work Group Proceedings*. Rockville, Maryland: U.S. Department of Health and Human Services.

8. See quarterly and annual reports of the National Institute of Justice's Drug Use Forecasting Program, available from the National Institute of Justice/NCJRS, Box 6000, Rockville, MD 20850, 800-851-3420.

9. The White House. 1991. *National Drug Control Strategy*. Washington, D.C.: U.S. Government Printing Office, p. 107.

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Note: Asterisked items are available free from the National Institute of Justice/NCJRS, Box 6000, Rockville, MD 20850, 800-851-3420. Cite the NCJ number when ordering.

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Marcia R. Chaiken, LINC, conducted the study described in this *Research in Brief*. The full report of the study, *Identifying and Responding to New Forms of Drug Abuse: Lessons Learned From "Crack" and "Ice,"* will be published as an *Issues and Practices* report of the National Institute of Justice.

Findings and conclusions of the research reported here are those of the author and do not necessarily reflect the official position or policies of the U.S. Department of Justice

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Sources of Additional Information

National Institute of Justice/NCJRS
(National Criminal Justice
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800-851-3420

National Institute of Justice
Data Resources Program
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Washington, DC 20531
202-307-2961

Drugs & Crime Data Center
& Clearinghouse
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Rockville, MD 20850
800-666-3332

National Institute on Drug Abuse
National Clearinghouse for Alcohol and
Drug Information
P.O. Box 2345
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800-729-6686

Drug Enforcement Administration
Office of Intelligence, Publications Unit
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American Council for Drug Education
204 Monroe Street, Suite 110
Rockville, MD 20850
800-488-DRUG (3784)

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