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**Investigating Recent Trends in Heroin Use in Baltimore
City: A Pilot "Quantitative" Research Project**

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PREFACE

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ACQUISITIONS

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INVESTIGATING RECENT TRENDS IN HEROIN USE IN BALTIMORE CITY

The drug field relies on systems of epidemiologic indicators to monitor trends in drug use. The indicators typically represent drug treatment admissions, emergency room mentions of drug use, and arrest statistics, although there may be others as well. Recently, in Baltimore, a puzzle emerged, a disjunction between what people said was going on and what the standard indicators revealed.

The word from treatment professionals and others close to the street scene was that the heroin available was of high quality, abundant, and cheap and that people were using it in increasing numbers. Some of the indicators did, in fact, show an increase in heroin use, but not the sort of increase one would expect given the comments of knowledgeable individuals close to the street scene. Treatment admissions went, in round numbers, from 6,400 to 7,900 to 8,400 for fiscal years 1989 through 1991 (Maryland Alcohol and Drug Abuse Administration, Substance Abuse Management Information System, October 1993); emergency room mentions went from 575 in the fourth quarter of 1990 to 1,139 in the same quarter in 1991 (Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network, May 1993 files); but, most puzzling of all, the rate of heroin-positive urines among a pretrial population showed no change, 22% at the end of 1991 and 1992 (Baltimore City Pretrial Services Agency, 1993).

The numbers increased more by the time we finished the study we are reporting here, but more on that in the Conclusion. The point was, how could people be saying that heroin use was epidemic if the epidemiologic indicators were not going through the roof? Why was there such a large difference between the subjectively perceived epidemic on the part of knowledgeable professionals and what the indicators showed, an increase to be sure, but not a dramatic one?

In coordination with the Center for Substance Abuse Research (CESAR) at the University of Maryland, we formulated a qualitative research strategy for tackling the question. As anthropologists, we were interested not only in the specifics of the particular problem, but also in the more general issue of conducting limited ethnographic research. While we will develop more on this issue in the Conclusion, as anthropologists, we are often faced with the quandary of holding to ethnographic research standards, which eliminate the possibility of conducting partial qualitative work. However, in this particular case, we saw an opportunity to introduce a limited and focused use of qualitative methods around a problem in understanding the epidemiologic data. Specifically, we thought that ethnographic interviews, targeted on treatment professionals and addicts close to the current street scene, would open up a space for them to articulate their observations. We hoped that conducting a simple topic and content analysis of what they told us would suggest reasons for the current trend of heroin use and help us understand why that trend had not appeared as strongly in the indicators as it should have.

Ethnography this is not, but ethnographic in interview format and analytic strategy it is, indeed. No one would take a brief study like this as conclusive, but conclusions are not the goal of this kind of study. Ideas are, ideas with which to set up hypotheses, broadly construed, that aim at a better understanding of the relationship between human situations and indicators that professionals define to understand them.

METHODOLOGY

We conducted interviews with medical, treatment, and law enforcement professionals and with heroin addicts who had recently entered treatment. The professionals, because they were situated near but not in the Baltimore drug scene, were in a position to make long-term observations about what was going on out on the street. They could provide a more global perspective on what had happened over the past couple of years. In a sense we were asking them to be "folk ethnographers" for a day, to draw on their observations, insights, and folk theories about what was going on in the Baltimore drug scene. We located them by networking through a list of contacts provided by CESAR. We conducted five "professional" interviews with six individuals from East and West Baltimore (Figure 1).

We conducted five additional interviews with heroin users who had recently entered treatment (Figure 2). These individuals represent a convenience sample recruited by asking treatment personnel to introduce us to one or two individuals who were just entering treatment. The five people interviewed were recruited from three methadone programs in East and West Baltimore. All five had been using heroin for at least 10 years. Four of the five had been in drug detoxification or treatment at least once before their current admission. Four of the heroin users were men in their late thirties or early forties. Three of the men were white and one was an African-American. We conducted one interview with a white woman in her late forties, who had been using heroin for 22 years.

Figure 1. Medical, Treatment, and Law Enforcement Professionals Interviewed

- Intake Coordinator, Methadone Clinic, West Baltimore
- Narcotics Officer, Baltimore City Police Department, Narcotics Division
- Director, Methadone Clinic, West Baltimore
- Nurse Supervisor, Methadone Clinic, East Baltimore
- Two Addictions Counselors, West Baltimore

Figure 2. Heroin Users Interviewed

- White Female from West Baltimore, Early Forties
- White Male from West Baltimore, Mid-Thirties
- White Male from East Baltimore, Late Forties
- White Male from West Baltimore, Early Thirties
- African-American Male from East Baltimore, Late Forties

This group of heroin users is by no means a representative sample of Baltimore's heroin-using population. They are older and disproportionately white. Nor do any of the interviewees represent groups in which the changes that we will report have occurred. The nature of this convenience sample will lead us in the Conclusion to discuss problems in selecting informants in "quantitative" studies.

THE "HOG HEAVEN" MODEL

In 1990 the Baltimore City Police Department began monitoring a rise in the purity of heroin coming into the city. The average purity of heroin obtained during this period from arrests and "controlled buys" rose from 4.1% in 1989 to 6.2% in 1992. During this same period, a number of "trademark" packages also began appearing on the streets. The trademark packages, which were bagged for street sale, were largely confined to one neighborhood in West Baltimore and averaged 70.1% in purity.

Some of our interviewees did report a rise in the quality of street heroin. One man in his late thirties, who had relapsed into drug use early in the spring of 1993, reported that he "could get a \$10 bag and take three different shots off of it. And I mean I would throw up, I was so high I was throwing up after each shot." Most of the treatment professionals with whom we spoke remarked that they were seeing more people testing positive for heroin, even after they had been on methadone for extended periods of time. Because it is difficult to get high on heroin after being medicated on methadone, many of the treatment professionals viewed the high number of "heroin positives" they were seeing among their client population as evidence that the heroin on the street was high-quality heroin.

But not everyone we talked with was willing to say that the quality of the heroin had gotten substantially better in the past two years, in part because of the uncertain nature of buying heroin on the street. The quality of the heroin might be better in general, but it might be hard for buyers to gauge because a heroin addict never knows when he or she is going to get burned, that is, sold heroin of poor quality. For example, the woman we interviewed, who had been using heroin for 22 years, put it this way:

I personally don't think that the purity is going up. But, like, right now the dope around Greenmount and Twentieth is exceptionally good, but in two weeks, even a week, it might be garbage again.

For her, there was no way to know in advance just how good the heroin was, because the quality of heroin is so variable. Just because a "package" has been good for weeks does not mean that it will not suddenly "fall." This may lead to ambiguous perceptions of just how good the heroin on the street has been in the recent past. The woman quoted above is a good example of this ambiguity. Yes, she says, she had been getting good dope these past few weeks, but on the whole, the dope was not really that much better.

Such ambiguity was expressed in one form or another by two of the other addicts with whom we spoke. They also felt that the quality of the heroin on the streets was not that much better than it had been two years ago. Yes, they would say, I've been getting better dope recently, but heroin on the whole was not that much better than it was before.

When addicts talked about the cost of "getting well," however, the ambiguity disappeared. As the female interviewee put it:

Like I said, that might have something to do with the price, where two or three years ago you had to get \$25 together. Now you get \$10 together and you're basically doing the same thing. In other words, \$25 would get you just well enough to get out there and hustle for the rest of it. You know you'd feel better. And it's the same thing with the dime now.

The change in the price of heroin is reflected dramatically in the way that heroin is packaged for street sale. Two years ago most dealers sold street-level heroin in \$25 bags and \$50 "jumbos." As one addict put it, the \$25 bag "would just about stop your nose from running." Over the past year or so many of the dealers in Baltimore have gone to selling heroin in \$10 capsules or bags. "Now," as the addict quoted above continued, "all you have to do is get \$10 together to get yourself well enough to go out and hustle up the rest."

Whether the price has actually fallen is a matter of some debate. But regardless of the price of heroin, there has been a drastic reduction in the amount of money a heroin addict must "hustle up" to get well and support a habit.

All of the treatment professionals with whom we spoke remarked about the decline in the amount of money that addicts reported spending on their heroin. They said that many of the addicts reported spending less than \$100 a day on heroin and that they had never heard of a serious heroin addict spending less than that until recently. As one of the treatment professionals explained:

One of the things that we've noticed in the last year is that our new admissions coming in were not reporting spending the amount of money that they normally were reporting--we were used to seeing a \$100-, \$200-a-day heroin habit. So when we had the addicts coming in saying that they were spending \$60 and \$80 a day, we were thinking that they weren't using much, you know. And then the more we'd talk to people, the more we found out that the heroin, the quality, was much better. So we're now seeing instead of \$100-\$200 a day, we're seeing between like \$60- and \$80-a-day habits.

Although many addicts insist that they are "hogs" and will do as much dope as they are able to buy, there does seem to be a limit to the amount of heroin that most of the addicts we talked to would do. As one heroin addict in his late thirties put it: "If I go out

and buy 10 caps I'm not going to pour all 10 of them in the cooker. That would be suicide. I just don't do it."

The availability of heroin is another area of profound change in the drug scene over the past few years. Everywhere we went people talked about how plentiful and readily available heroin was on the street today. Many people we talked to described a "supermarket" atmosphere. A heroin user in his late forties described a situation in East Baltimore where dealers had people lined up next to an alley. One person in the alley was collecting money and another was handing out \$10 capsules. Another addict reported that, whereas it used to always take more than an hour to cop in the past, he could go in and cop in less than 15 minutes. Another man reported:

Oh yeah, copping's real quick now. But it used to be, I mean, I remember years ago when it would be--you would go to one corner and give the money up front. And you'd go to one corner and give the runner the money. And then he'd send you to another corner. And then you'd go sit there and then somebody completely different might come by. I mean you might be sitting there in your car with your window down and out of nowhere--boom, bag of dope comes flying in the window. And you happen to look around and see someone come scooting by on a bicycle. And that's how it used to be then. And I said you had to trust them because you had to give the money up front. But now you just pull up in the car. And as soon as you pull up, they'll say how many and you hold up two fingers. You hand them the money and they hand you the stuff--boom you're out of there. Yeah it's a lot faster now, it's just in and out.

Other people remarked that the hawkers, who had been absent for a long time, seemed to be making a comeback. One of the treatment professionals with whom we spoke said that it was impossible for his staff to drive through any of the neighborhoods where heroin is sold without being approached by hawkers. The man quoted above remarked that he had seen dealers and runners approach just about every car that drove through the neighborhood where he used to go to buy heroin.

The combination of relatively abundant, low-cost, high-quality, readily available heroin has led to conditions where the epidemiologic indicators are not behaving in ways that we would have expected them to behave. The question then becomes, How does this heroin epidemic differ from past heroin epidemics and from the assumptions that we are making about heroin epidemics in general? In answering this question we are essentially trying to portray how street conditions today differ from street conditions in the past.

WHY HOG HEAVEN?

How the conditions that gave rise to the "hog heaven" model emerged is one question that we will attempt to answer. How the conditions have affected the statistical indicators in Baltimore is another. In this section, we examine how the conditions arose.

The conditions that gave rise to "hog heaven" are the result of a number of emergent factors that have interacted synergistically to produce the current street situation. One of the factors that weighs heavily in the equation is the cocaine epidemic of the late eighties, an epidemic that acted in concert with changes in the way that heroin is distributed and marketed to produce the current street situation in Baltimore.

Cocaine, and especially crack cocaine, was late in coming to Baltimore City. The epidemic of cocaine addiction that emerged in other major American cities in the early eighties did not begin to hit Baltimore until the late eighties. In the fourth quarter of 1989 there were fewer than 400 emergency room mentions of cocaine. By the fourth quarter of 1991 there were over 1,300 emergency room mentions, a 225% increase. According to one person with whom we spoke, the crack that did finally show up on the streets of Baltimore was of poor quality generally and many of Baltimore's cocaine abusers preferred to inject their cocaine.

Ironically, many young heroin users in Baltimore today seem to have gotten into heroin through cocaine. This is contrary to the traditionally perceived patterns of drug use, wherein cocaine and heroin abuse are seen as distinct phenomena. Many of the cocaine addicts needed something that would mellow them out, that would bring them down after they got "coked out." As one treatment professional put it:

The cocaine epidemic, I think, had a lot to do with that. That brought everybody back to heroin again. Whenever you see an outbreak of cocaine, I think it's safe to say that an increase in heroin usage will soon follow. Cocaine is not a very pleasurable drug to use by itself for long periods of time. It is a stimulant and it wires you out so much you get so nervous, so jittery, that it's not very pleasant. You need something to come down with. Alcohol--very popular drug to do that with. In fact very few cocaine users that I personally have interviewed will tell me that they will use cocaine and not use something as a counter to it, as a sedative. Alcohol would be a very good one to use but a lot of the cocaine users tell you that after a while they can't get enough of it down quick enough to get the calming effect. The tranquilizer pills are popular, but again, a pill takes, you know, could take an hour to come on and it's not, sometimes with that cocaine you are in such a thing you need to come down quick. Heroin is just perfect. Cocaine, after you're wired out on that, after you do some heroin that will smooth out the unpleasant side effects of the cocaine.

Heroin seems to "mellow" the cocaine user out and makes it possible to get over that "coked out" feeling. Thus, heroin and cocaine usage seem to reinforce each other. One of the heroin addicts we interviewed talked about the experiences of her brother:

When he goes on a coke binge, he might be out for a day and the next thing you know, he's on the phone to me, "I've got to get a shot of heroin, I've got to calm down."

Many of Baltimore's newer heroin addicts, according to our interviewees, followed this path into heroin addiction.

Most treatment personnel we interviewed in Baltimore noticed this phenomenon. According to them, many users who now present themselves for detoxification or treatment are dually addicted to cocaine and heroin. One treatment counselor remarked that almost all of the urine specimens that they were testing prior to admitting clients to treatment were "testing out morphine, quinine, cocaine."

This pattern of combining heroin and cocaine use is different from the pattern of heroin abuse established in the previous generation, yet it seems to be the pattern that the treatment professionals in Baltimore are seeing today:

The only thing that's significantly different--that 8 out of 9 or 9 out of 10 that we're processing out are heroin and cocaine. There is no just heroin. I mean because they use whatever's available. There's plenty of cocaine on the streets. It's cheaper, it's \$5 caps and they speedball them, using heroin with the cocaine.

The change in the market (who is using heroin) for heroin coming into Baltimore City mirrors changes occurring in the way heroin is distributed on national and local levels (who is selling the heroin). As the cocaine epidemic of the late eighties and early nineties reached its peak, many cocaine traffickers realized that the market was saturated and turned to heroin as a means of keeping and expanding their markets. The convergence of these two phenomena has had a profound effect on the street-level situation in Baltimore.

Cocaine and heroin are now available on the same street corners in many areas. Many of the users we spoke with remarked that this was a recent phenomenon. They noticed that some cocaine dealers had moved into the heroin market. Now they sell both, dealing both "boy" (heroin) and "girl" (cocaine) alongside one another:

It seems like when the heroin got so bad, two, three, four years ago, somewhere in there, that they went over to doing coke. Now that the heroin is back, not that it's better, it's just back, apparently the shipments are getting through, or whatever the problem was. Then they're back dealing their heroin, so now they're dealing both.

On the international level, there have been changes in the distribution of heroin as well. An in-depth examination of these changes is beyond the scope of this report. According to media reports, however, the Cali and Medellin cocaine cartels have become extensively involved in heroin trafficking over the past couple of years (*Washington Post*, September 1, 1991). There have also been reports that poppy production has increased dramatically worldwide (*Washington Post*, April 29, 1993).

This combination of changes in both the user base and in the way heroin is marketed has had a synergistic effect in this case. The cocaine epidemic of the late eighties helped to create a demand for heroin concurrently with a rise in the heroin supply. As a result, relatively good quality, inexpensive heroin is readily available to any number of new users who are attracted to the drug.

MAKING SOME SENSE OUT OF THE NUMBERS

One of the most puzzling statistical conundrums in the rise in heroin use in Baltimore has been posed by data on the city's pretrial release group. During the heroin epidemic in Washington, D.C. in the late seventies, and in the cocaine epidemic of the late eighties, this was the first group to show a rise in illegal substance use.

Encounters with the legal system are somewhat unpredictable, but junkies are at risk of arrest when they buy dope, when they shoot up, and when they engage in criminal activities to support their habits. There is, in short, a constant threat of arrest. Long before most addicts reach the stage that they are seeking treatment or ending up in hospital emergency rooms, there is a good chance that they will cross paths with the legal system.

So why has there not been a rise in the number of arrestees testing positive for heroin during the period they are under pretrial supervision? Part of the reason may be that less money is needed to maintain a heroin habit.

As noted above, all of the treatment professionals mentioned that the amount of money addicts reported spending was down drastically. It was not uncommon, they said, to have long-time heroin users report spending between \$60 and \$100 a day on heroin, considerably less than the \$150-a-day habits reported only two years ago.

But the price of heroin is only one factor in the overall cost of a heroin habit in Baltimore. The cost of maintaining a heroin habit includes such things as the amount of time involved in copping and the amount of time it takes to hustle up the money required to support a habit. If heroin is relatively abundant, low in cost, and more readily available than in the past, it stands to reason that this might translate into fewer encounters with the legal system. The director of a methadone program in West Baltimore put it this way:

I can't help think that the low cost of the drug had a lot to do with that. That if you don't have to steal as much you're not going to get caught as much. You know the 10 to 20 to 30 dollars a day is not that hard to hustle up, as opposed to two years ago when addicts were telling me that they would have to do at least three or four of those 50 or 55 or 60 dollar bags a day. So I think that the price of the drug has a tremendous impact on the crime that goes along with it.

Lowered cost also has an impact on the ways in which people are able to support their habits. Most of the heroin users that we interviewed in Baltimore supported their habits primarily by working a steady job. With the cost of maintaining a heroin habit as low as it is, it is possible that far more addicts are able to support their habits in this fashion:

I got a real education when I was involved in that murder case. Because this was a young man that was 19 years old. That was in 1987 when he had shot this police. And as I talked to him, you know, he continued to reveal to me ... how many more of the younger addicts were working and were not really involved in the criminal element.

Because the cost of supporting a habit has gone down, because the heroin that is available is of good quality, and because the heroin that is out there seems to be readily available, addicts probably have fewer collisions with the criminal justice system. This may be especially true of people who have just gotten into drug use. It may take longer for them to get to the stage that they become involved in the criminal justice system.

THE INSTITUTIONAL MODEL: THE ROLE OF PUBLIC ASSISTANCE AND HEALTH INSURANCE

The "hog heaven" model described above emphasized changes that have occurred on the streets over the past few years. Those changes produced conditions whereby the standard epidemiologic monitoring systems did not register the increased heroin use in the same way that they had in the past. There are also indications that changes within the institutions where the epidemiologic monitoring systems operate have kept the numbers from behaving in ways that we would expect.

It is not clear whether the change has been in institutional policy itself or in the way that institutional policy is perceived among client populations. But there is a general consensus among the treatment professionals with whom we spoke that it is harder to get health insurance companies to pay for drug-related admissions (treatment or otherwise) and that it is harder to get treated in hospital emergency rooms because of cuts in public assistance.

A treatment professional from West Baltimore said that he had noticed that things had

gotten worse for the people he was dealing with:

It's really gotten worse since last fall; it's really gotten worse. Because they did away with medical assistance. It used to be that hospitals would pick some of them up. Because there is no treatment available, people aren't even coming forward. People aren't even going to hospitals unless they're shot or something happens because hospitals turn them down. There's no insurance.

He went on to describe the effect that this has had on the indicators:

They weren't turning to programs, which are a source of statistics.... When the availability [of drugs] is high the admission to programs is low. Requests for treatment, well that's not a barometer anymore because all the programs in the state have a four-month waiting list. There is no program that you can get in and the hospital emergency room's out, that's out because people don't go to the hospitals 'cause they know they can't get served anymore.

One heroin addict described it this way:

You know there's also the rumors going around. You know my mother's a nurse and she tells me how they killed a lot of detox programs and stuff. And a lot of people are just there figuring, especially if they've got medical assistance, that well they're not going to pay for it, so I'm not going to get any treatment anyway.

Many people with whom we spoke said that addicts admitted to detox through the emergency room had their length of stay cut from 30 days to 3. And, they would say, what addict wants to go through 3 days of detox and get back out on the street? There was some indication that addicts sometimes presented themselves at hospital emergency rooms and reported other complaints in order to get help. One story that we heard involved an addict presenting himself as suicidal or severely depressed. He could then be admitted for an acute psychiatric condition.

Interviewees felt that many addicts were avoiding the emergency rooms unless they absolutely had to go for an acute condition. Several of the treatment professionals had noticed a general decline in the health of the addicts who were coming into treatment. They attributed this decline to the difficulty many addicts had in finding treatment, as well as to the rise in HIV infection among intravenous drug users. Many people were also avoiding treatment because the wait for a treatment slot was so long.

The discussion so far has applied mainly to people on public assistance. There are also indications that some private insurers are making it harder to get reimbursed for drug treatment. As one medical worker in East Baltimore remarked:

One of the things we have noticed with some of the higher socioeconomic families

and the ones whose parents have clout or are socially in a position that god forbid their kids be into drugs. When those kids overdose and go into emergency rooms it's immediately diagnosed as something else. It's diagnosed as depression, a manic depressive disorder, a psychiatric crisis. And now drug treatment programs are having more problems with insurance companies. Because insurance companies don't want to pay for drug treatment anymore for more than 3 days ... [they] decreased people going [into] recovery from 28-30 days to 3 days. And they realize that they are liable when the 3 days are over with and a patient OD's or they're just now going into withdrawal symptoms that become serious. One of the things that I think some drug treatment programs and I mean the whole system is trying to do is relabel why they went into the hospital.

There does seem to be a widespread perception that institutional changes have made it more difficult for people presenting themselves for treatment of drug-related problems to get their treatment paid for. People are staying out of hospital emergency rooms, or trying to get in through the back door, because they believe that they will not be treated if they do take the trouble to present themselves. People have not been showing up for treatment because they do not believe that there is treatment available. That perception has been enough to change their behavior and, thus, the extent to which the epidemiologic systems reflect current conditions on the street.

WORST-CASE-SCENARIO INSTITUTIONS

This pilot study has led us to consider the dynamics of what the epidemiologic systems are monitoring. With an average 10-year lag between a heroin user's first use and first request for treatment, it is likely that many of the newest heroin users in Baltimore have yet to encounter a monitoring system. If this is the case, the rise in emergency room mentions of heroin and requests for admission to treatment is still somewhat of a puzzle, even though the numbers are not as high as expected. If we think about where the numbers are generated--hospital emergency rooms, the legal system, and admission to treatment--they are the very places that addicts usually try to avoid.

When do addicts show up in hospital emergency rooms? When they overdose. They might come in for another acute condition, such as an injury. If they do not have any insurance, they might show up in the emergency room as the result of a chronic ailment. It is probably also safe to say that most addicts do their best to avoid being arrested, and most addicts seem to avoid treatment until things become intolerable:

I think that the addicts that get themselves addicted to heroin will stay out there until the conditions start getting intolerable for them. Money--the addict will first use all their assets, sell everything [they] own--steal what they can from people that are safe to steal from. Family--family doesn't get you locked up usually. And then when they start branching out after that some will get in trouble with the law and then try to get

into treatment. Others will just find it too difficult to try turning up that money and they get tired of getting ill. So they'll come looking for treatment. We don't know how many people are doing heroin because it's the fun stage. These people are having a hell of a good time. So until there's complications and problems nobody comes looking for treatment while they are still enjoying that high. So you know in a way wonder how many are out there in that stage particularly with prices of the drug getting as cheap as they are. You know an addict is spending \$10 a day, that's not a hell of a lot of money. I have friends that probably spend that much, that like going to restaurants and night clubs every week, and are spending that kind of money recreationally. So you know the cost factor is down, the quality of the drug is pretty good. I believe that you've got a lot of people that are using that are not putting the demands on the treatment.

Another addict put it this way:

Oh yeah man I've never sought treatment because I had trouble finding dope. I just get so disgusted with the whole scene you know. It really irks me to give these guys all my money. I mean it's just a lot of stuff you know. I just get tired of sponging around and tired of being broke. Christ I've driven new cars up my arm and shot houses. And you know sometimes I just get depressed with all of this shit. Plus like I say just the whole scene you know. I mean especially you been sick all day. You're trying to get money together and you scrape up \$20, then you get it home and it's a burn you know. That's just kind of like icing on the cake. I mean even if I'm dealing with you ... and I've been dealing with you. And it's happened before I get it home and it don't even stop your nose from running. Then it's an adventure to have to go all the way back down there and stuff. And then plus you don't want to go back down there without no money in your pocket. Because you're going to go down there and squawk about this and he's going to say I'll straighten you out but I can't now because I got to get my money right here. And so you're down there with no money you know and that kind of compounds everything. I mean when I go to a program you know I'm like hittin' the bottom of the barrel you know I've about had it.

Treatment centers, hospital emergency rooms, and the legal system are "worst-case-scenario" institutions. That is, the places where the epidemiologic systems operate, the places where addicts have to show up before they can be counted, are places that most addicts spend time trying to avoid. Given the "hog heaven" conditions on the street today, as well as changes in the perception of the availability of public assistance, it is likely that many new heroin users will take longer to cross paths with these worst-case-scenario institutions.

Most new addicts are not going to show up looking for treatment or become entangled with the criminal justice system until the heroin costs more or declines in quality or availability. Those are the conditions that send addicts into treatment. They will not seek

treatment until they start scraping the bottom of the barrel. One woman remembers a time two years ago when such conditions existed:

Two or three years ago, though, just got shitty, everywhere. You know West side, East side and if you look back on the records a lot of people got on programs around that time. Because the dope just got so bad, so stepped on, so scrambled.

Emergency rooms are also worst-case-scenario institutions. When do junkies end up in emergency rooms? Often they appear for chronic complaints that have reached the point that they are unbearable. New users typically do not go to the emergency room because they have not reached a stage where the chronic effects of heroin use will drive them to seek treatment.

Acute problems, such as overdoses, are harder to control. If the heroin out on the street is as good as everyone says it is, why aren't more people showing up in emergency rooms after overdosing? In the interviews, we learned about self-monitoring strategies that might account for this.

Earlier, we quoted an interviewee saying that he didn't dump 10 caps in a cooker, because he just never did 10 caps at one time and doing 10 would have been "suicide." He said later on that he might go out and dump 3 caps in a cooker at one time because he is accustomed to doing 3 caps and if the heroin was really good then he "wouldn't have to worry about copping anymore."

Another interviewee echoed these sentiments:

If I've heard of this like really killer, killer dope, you know, I'll get say, say I get five dimes. I'll run home and do one. You know, see what it is and then I know how much of it I can do. And quite often, quite often you're with other people when you're getting ready to get high. Say three or four of you, not a gallery so much as just three or four of you went together and you all go back to her house or your house. And they're all getting off. And somebody gets off first and you just look at them. You can look at their eyes and hear the change in their voice, and estimate what kind of dope it is. If you know the person and know what they're used to being able to do.

CONCLUSION

What did we learn from the interviews? What sort of model do we have here, based on what the treatment professionals and addicts in treatment told us?

First, the interviewees confirmed what we'd heard people were saying--that from the heroin consumer's point of view, life couldn't be better. Heroin is available, cheap, and

easy to get. The hassles of the heroin-using life have been considerably reduced, something we called the "hog heaven" model.

Second, we learned two interrelated explanations for the change. From the user's point of view, we learned that heavy cocaine use, whether injected, snorted, or smoked as crack, contained within it an instrumental tendency to use heroin. In addition, we learned that the global drug business is shifting right now toward heroin, both in production and distribution. The two factors, taken together, outline a historical process that might explain how one particular drug trend leads to another, powerfully so when it is in the interests of both producers and consumers.

Finally, we heard two reasons why the standard epidemiologic indicators hadn't gone through the roof. First of all, institutional policies vis à vis drug use are said to have shifted away from providing resources for drug treatment. If true, the shift would in itself produce a decline in indicator numbers. Second, we learned that most indicators are gathered in worst-case institutional settings, settings that users seek out as a last resort when their situation turns desperate, and the "hog heaven" situation in Baltimore is less likely to make addict's desperate.

That's the good news, so to speak. An explanation, offered as a hypothesis, that draws on the expertise of those close to the scene to make explicit some ideas about the ties between epidemiologic indicators and actual patterns of use.

There is some bad news, or at least reason for cautionary comment, as well. First, the most recent epidemiologic data, gathered after we finished the study, do show a continuing growth in the indicators. Emergency room mentions were at 1,314 by the fourth quarter of 1992, an increase from the 1,139 when we started the study. Treatment admissions were up to 9,461 in fiscal year 1992, but then down a bit, to 9,064, by the end of fiscal year 1993, an increase over the roughly 8,400 when the study began in the spring of 1992. This is to be expected, but we are not sure how to interpret it. On the one hand, perhaps the indicators are simply more "lagging" than "leading." On the other, perhaps the increase still does not warrant a judgment that an epidemic is ongoing, but because a baseline set of expectations and guidelines for how much change is significant is lacking, we cannot make that argument statistically one way or the other. And finally, we can speculate that many of the addicts entering treatment today are not new drug users. Rather, they are dually addicted and came to heroin through cocaine and, thus, are farther along the curve and more in a position to encounter worst-case-scenario institutions.

A second cautionary note: In retrospect, we see that our addict sample was not representative of the general heroin-using population. It did not include any new users of heroin, nor did it go outside the networks of the very epidemiologic system it was intended to qualify. Here, we hit a frustration for limited qualitative work--such work, involving as it does the elicitation of uncontrolled interview data and the pattern analysis of that same material, requires more time than a survey. We coped with the practical limits on the

"quantitative" work by following the available networks and pulling out interview segments most relevant to the question at hand. Thus, while we believe that the results were worth the effort, and colleagues in the Maryland Statewide Epidemiology Work Group seemed to find it interesting and useful as well, we are now working to refine this epidemiologic/qualitative methodology to resolve such issues to the extent possible.

At the same time, we think that the use of qualitative methods to convert epidemiologic indicators into uncontrolled expert voices is worth the effort, as long as the results are not construed as ethnography nor as conclusive, but rather as part of a process to move toward a better understanding of drug use trends. The problem for ethnographers will be the challenge of configuring specific qualitative methods that respond to both intellectual quality and practical needs. The problem for epidemiologists will be to respond to the suggested complications that the qualitative methods yield as they show the limits of the indicators and the "unindicated" historical and social patterns that help explain trends in use.