ICE AND OTHER METHAMPHETAMINE USE: AN EXPLORATORY STUDY

FINAL REPORT

The National Institute on Drug Abuse

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- FACT: Begining in 19____ I started ...

- FACT: In 1994 I saw report N I D A ...

- FACT: In 2000 the author flew to Hilo
  News paper covered story
- FACT: Mayor Kim sign proclamation ICE.
- FACT: In 2002 "Meth Summit"
  1. passed out N I D A
  2. saw BI get Big #
  3. met D E A Hutchess

FACT: N. I D. A. desappears/no reference

- FACT: In 2003 "Meth Summit"

- FACT: In 2004 "Met Summit"

  met Bill Phillips
- ~~FACT~~: 2005 Rep ~~Zauder~~ Souder
- FACT: In 2006 in Meth Reports Hawaii

  is not even listed Glaring Ommissions Why?

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ACKNOWLEDGEMENTS

Exploratory community-based research of "hidden populations" are always challenging. When the study incorporates a qualitative naturalistic design aimed at previously "unknown" users into a multi-cultural, multi-site framework, the challenges can be overwhelming and relentless. Such was the case with this study. As the only recent NIDA funded community-based study of methamphetamine use, it was also one of the most extensive qualitative research efforts involving 450 respondents in three sites. Moreover, this community-based qualitative design was the first federally funded study of its kind to take place in the State of Hawaii. It represented the initial effort to conduct urban ethnographic research among illicit drug users, especially use among Asian Pacific Islander ethnic populations. Additional challenges included extremely hidden user groups in the California sites.

Directing research through these complexities was a rich experience. It revealed that when successfully met, these challenges substantially enhance the collection effort, enrich the theoretical and substantive contribution, and expand the potential for future research. Our success was based in large part on the commitment and hard work of an extremely capable research staff. This team effort allowed me to survive this first experience as a Principal Investigator. Jerome Beck and Doug McDonnell took primary responsibility for the San Diego and San Francisco study site. Karen Joe established and oversaw the research effort in Honolulu. Rhoda Estep was central in the design of the quantitative instrument and code book. In addition, Doug McDonnell developed an excellent data management plan and diligently worked with the interviewers in every study site. Maureen Alioto extended her commitment beyond her excellent work as transcriber to help with coding the qualitative data, and provide administrative assistance as well. The person who held it all together was Rachel Gutierrez. As administrative coordinator she kept the whole process running smoothly in all four offices, as well as providing invaluable research assistance. She maintained the current demographic data file, and assisted with coding and memoing the interview data. I am very grateful to each one of these dedicated colleagues.

I also recognize how fortunate we were to work within a supportive institutional environment. I would to thank Dorothy Miller the scientific director of the Institute for Scientific Analysis for giving me the opportunity to direct this research study, and the encouragement to carry it through. I am also grateful for the unrelenting guidance provided by the Institute's administrative director Setsu Ota-Gee. Somehow she managed to allow the Principal Investigator intellectual freedom, while keeping me from making too many mistakes. Finally, I would like to thank Sandie Spacek for her patient help and support as I stumbled through each new administrative experience.

This research study was also strengthened by the substantial support received from the staff at NIDA. I would like to thank Dr. Zili Sloboda for believing in the significance of the problem, the worthiness of this research, and the capability of the principal investigator. I am also grateful for awarding us additional time and funds to extend analysis of our findings. I am especially indebted to our project officer, Mario de la Rosa. Beginning with the very first phone conversation on the feasibility of writing the proposal to the final analysis phase, his genuine concern and commitment to the project and its principal investigator never wavered. My enormous respect for Dr. De La Rosa's intellect, professionalism, and collegiality accompany my sincere gratitude.

Our ability to meet the challenges facing this complex and ambitious qualitative study in each community necessitated a great deal of collaboration and assistance from myriad individuals at every phase of the research. We were extremely fortunate to have had overwhelming support we were able to receive from the community itself; from research, professional and community consultants, and especially from key agencies and organizations in all three study sites who substantially facilitated our research effort. It would be impossible to acknowledge separately the more than 100 individuals who provided consulting support for this study. A complete list of names is found in Appendix D. The contributions of certain individuals, however, were vital to the success of the project in each study sites.

In the San Francisco site, we are especially grateful to Dr. John Newmeyer for sharing his vast knowledge and experience in the field, as well as his assistance in helping to locate key inner city experienced users, and identify essential emerging problems and user populations. The study also benefitted a great deal from his willingness to serve as a consistent resource throughout the life of the project. Dr. Elliot Currie provided the same support for the East Bay component of the study. We were also able to enlist the help of program providers with experience in these communities (see Appendix D). The comprehensive efforts of several interviewers were key in accessing and following chains of difficult to reach user populations. They are Toby Marotta, Brooks Penny, Randy Paulson and Donna Weeks. Finally, the study in San Francisco was able to build on the existing resources and knowledge built up in previous urban ethnographies. We were very fortunate to be able to call upon colleagues Dan Waldorf, Shiegla Murphy and Marsha Rosenbaum for their help and suggestions.

Research in the San Diego site benefitted early from the efforts of Dr. Felipe Castro who provided rich baseline information on several user groups from his research findings on treatment populations. He was also instrumental in linking us to consultants from community agencies and programs. Consequently, we were able to enlist the participation of Dr. Al Velasco and the Sherman Heights Community Center as a vital resource. The Center served as our field office, and Dr. Velasco recruited community consultants from Latino programs and organizations. He also provided us with access to trained interviewers with previous research experience among Latino drug users, one of whom also served as our field coordinator. The commitment and contribution offered by Dr. Velasco, and the resources provided by the Center became a vital component of the San Diego study site. The consulting contribution of Dr. Michael Ann Haight and the San Diego County Drug Abuse Program provided another core resource. They were a consistent source of useful information and support; the agency offices were made available for focus groups, interviews and presentations throughout every phase of the research project. The third central component in the San Diego study was the successful establishment of a presence in the East County communities, due to the tremendous effort of Matt and Sally Fogg. From their initial contribution as community consultants, they eventually became the primary research staff responsible for interviews among key, previously hidden, user groups. Matt also contributed a wealth of ethnographic material on scenes, social worlds and local environments. They were able to compile a comprehensive demographic profile of East County community and resident characteristics.

As the first comprehensive community study of illicit drug use in Honolulu the study faced numerous potential problems. Qualitative naturalistic research was unknown, even among substance abuse professionals, and our target user groups were members of closed cultural and ethnic kinship networks never before opened to outside researchers. The study was able to overcome these problems thanks to the important support from key individuals and organizations. Among the first to offer support was Dr. Ken Willinger, from the State office of Alcohol and Drug Abuse Division. He was extremely supportive and the key in our introduction to substance abuse professionals in Honolulu by organizing meetings with the island's program and service organizations. Given the traditional mistrust of mainland outsiders, I was overwhelmed by the support we received. We were able to build and sustain solid working relations with many programs and organizations providing vital resources and links to the community. I was especially grateful to the support received during the initial phases of the study by Mason Henderson and the Sand Island Treatment Facility, the staff at the Drug Addiction Services of Hawaii providing a variety of intervention and prevention services, and Anthony Pfaltzgraff, director of the YMCA outreach service program, which focuses primarily on Filipino youth, one of our major target user populations.

In subsequent months, the directors of other key organizations helped to facilitate constructive working relationships with our research project. The study is especially indebted to Larry Williams, director of the Salvation Army Addiction Treatment Services program and to Sena Gates, director of the Community Health Outreach Service--or CHOW project. I am also grateful to the generous and continuous support provided by the State Alcohol and Drug Abuse Division directed by Dr. Elaine Wilson.

Major assistance was provided by a number of scholars at the University of Hawaii. Then chair of the Sociology Department, professor Gene Kassenbaum contributed departmental resources and space during the first weeks of the study. Professors Susan Chandler and Meda Chesney-Lind graciously shared their research and helped develop culturally appropriate items for the questionnaire, and connected us to other faculty as well as research staff. Later in the study, Dr. Amy Agbayani organized meetings with key individuals in the Filipino community, many of whom developed continuing ties to the research project. Dr. Donald Topping, opened up the resources of the Social Science Research Institute in the last months of the analysis phase when we again found ourselves without an office.

The response from many diverse communities in Honolulu was overwhelmingly positive. Appendix D provides a list of over 100 individuals contributed to this study, many throughout the life of the project, often refusing monetary reimbursement.

The contributions made by so many supportive individuals speak to the worthiness of this investigation. It was conducted on their behalf, and on behalf of the communities they represent. They made it possible for us to conduct this research **with** the community, and not merely **in** it. On behalf of my project colleagues, we would like to extend our gratitude in hope that this research will provide the basis for future collaboration.

Patricia Morgan

EXECUTIVE SUMMARY

DESCRIPTION OF STUDY

This report presents results from three year exploratory qualitative research into several previously unstudied populations of methamphetamine users. Data were collected from 450 interviews with community-based samples in the San Francisco, San Diego and Honolulu areas. The primary research goals were to uncover and examine the rationale, context, and patterns of methamphetamine use; the external and internal constraints which influence use; the links between these issues and serious mental and physical health, financial, social, and criminal problem consequences.

DEMOGRAPHIC CHARACTERISTICS

Over half of the Honolulu and San Diego respondents were under 30 years of age compared to less than a third in San Francisco Conversely, over 29 percent of respondents in San Francisco were over 40 years old, compared to less than 7 percent in San Diego, and 15 percent in Honolulu.

Whites accounted for over slightly over half our sample overall, but accounted for around three-fourths of respondents in San Francisco and San Diego. In Honolulu Asian Pacific Islanders accounted for over three-fourths of the sample. Overall, 10 percent of the sample were Latino, and 7 percent were African American.

Women comprised almost one-third of respondents equally across all study sites. Respondents identifying as homosexual or bisexual accounted for almost one third of the San Francisco sample, and for approximately 8 percent of San Diego and 9 percent of Honolulu respondents.

Respondents tended to have relatively low levels of education and income with significant differences by site. Honolulu respondents tended to have lower levels of education and higher income, compared to the San Francisco sample which had the highest level of education, and the lowest average income. We also found significant differences within sites.

The study identified several major user types: Marginal Anglo Working Class; "outlaw" bikers; "welfare moms," gays and bisexuals; long-time/marginal inner city user types; African Americans; Latinos; Asian/Pacific Americans; Honolulu inner-city homeless.

BACKGROUND CHARACTERISTICS

A high proportion of respondents grew up in disruptive family environments characterized by parental drug and alcohol abuse, physical violence, and sexual abuse. This is especially found among "local" Honolulu respondents, and innercity users in San Francisco.

Over 95 percent of the total sample have experience with alcohol, marijuana, and powder cocaine. Over two-thirds are familiar with the use of crack cocaine and psychedelics. Almost half have used heroin, and 60 percent report the use of tranquilizers.

Over two thirds of report moderate to heavy lifetime use of powder cocaine, with half of Honolulu users report moderate to heavy lifetime use of crack cocaine, compared to 14 percent in San Diego and 18 percent in San Francisco.

The 70 percent of San Francisco respondents reporting any lifetime heroin use is significantly greater compared to San Diego and Honolulu (39 percent and 27 percent).

Methamphetamine use is historically endemic to a number of economically declining, and marginal working-class communities in California which have identifiable "meth" cultures, spanning several generations in some families.

USE CHARACTERISTICS

A major finding was the lengthy careers of methamphetamine use found in our sample especially in San Francisco, where 42 percent reported 10 to 15 years of meth use, and 30 percent for 20 years or more, including 42 users who began in the 1950s and early 1960s. In Honolulu, the overwhelming majority began using meth after 1984 (86 percent). In San Diego over three fourths began using meth between 1976 and 1987.

There is a substantial population of long-time users who began using pharmaceutical pills for medical conditions and who made the transition to powder methamphetamine use. There were several overlapping meth cultures in San Francisco from the mid 1950s to the late 1960s which included users representing all socio-economic classes and ethnicities.

Modes of use reported by respondents at the time of interview differed significantly by study site. Injectors account for 67 percent of the San Francisco sample, snorters for 70 percent of respondents in San Diego, while 92 percent of the Honolulu users are primarily smokers. The use of a light bulb for smoking meth is particularly popular in San Diego, and widespread among both Hispanic and Caucasian users.

Most of our respondents in each study site were moderate to heavy users. In San Francisco, the average grams used per month were 6.6; in San Diego the average per month was 7.5 grams and in Honolulu it was the highest averaging 9.6 grams per month.

A substantial proportion of respondents describe being introduced to meth for work-related reasons, most at the work site, and many by their bosses.

The most frequently mentioned therapeutic rationales for using methamphetamine continue to be for weight loss and relief from depression. One unexpected finding was that over twenty percent of respondents who either had been or still were hyperactive, also found that methamphetamine had a calming effect. Similar attributions were reported by respondents with histories of asthma.

Most commonly mentioned motivations and attributions for initial stage of meth across all sites and user types were: increased energy and euphoria, improved ability to "function" and enhanced confidence, sociability, and self esteem. A substantial proportion, especially in San Diego, reported that methamphetamine extended their capacity and endurance for drinking.

A common evolving use pattern is toward binge episodes. Episodes tend to last longer than one day, with the majority of respondents averaging two to five day use episodes without sleep. Infrequent controlled use is fairly rare, more likely to be middle-class respondents, experienced users who are also dealers with a steady supply, or women with children.

There were marked similarities in the type of activity associated with "tweaking" behavior during heavy use episodes, which were gender specific. "Dumpster Diving" was a very common "tweaking" activity among younger respondents, especially in the California sites.

CONSEQUENCES

An unexpected finding concerned respondent beliefs about their addiction and loss of control over meth use. Almost two-thirds of respondents reported ever feeling addicted to methamphetamine, but less than half believed they had lost control over their use. Also, women were more likely to report feeling addicted to their use of meth than men, and less likely to report losing control over their use.

A high proportion of respondents reported the following serious consequences:

* Weight loss: most prevalent among women, especially in Honolulu (89%).

* Memory loss: half of all respondents reported some memory loss as a serious effect

* Depression: significant differences by site reported, 60 percent in San Francisco, 68 percent in Honolulu, but by 76 percent in San Diego. respondents

* Isolation: reported by most users, and almost all heavy frequent users in San Diego and Honolulu, tended to lead to paranoia

* Paranoia: mentioned by over half of our respondents, but by over two-thirds of the males in San Diego and Honolulu. Importantly, these users described very similar behaviors across all sites.

* Anxiety: reported by over half of all respondents, but in San Diego by three-fourths of the males and two-thirds of the females.

* Hallucinations: experienced by over two thirds of all male and female respondents, but significantly higher among both sexes in San Diego, and lower among all users in Honolulu.

* Violence: Honolulu respondents were more likely to report violent behavior due to meth use, and Honolulu females were over twice as likely to engage in violent acts than women in other sites.

* Meth use during pregnancy: This was reported by lightly more than one-third of female users overall, but ranged from half of the women in San Diego and only one-fourth in Honolulu.

* Needle Sharing: Almost half of the 138 respondents reporting they had ever injected meth, also admit to having shared needles.

* Sexual Behavior: Over three-fourths of respondents in San Diego and San Francisco, and two-thirds in Honolulu stated that meth use increased their sexual activity. A substantial proportion of respondents say that their use of meth also changed the **type** of sexual activity they normally engage in (52 percent in San Diego). Also, prolonged heavy use tended to result in sexual disfunction, as well as tendencies toward masturbatory behavior.

* Other Social Consequences: Financial problems, and problems with spouse, lover and friends were reported as serious consequences by over half of all respondents.

* Criminal Behavior: a very high proportion reported engaging in one or more criminal activities: over 94 percent of males and 91 percent of females. Burglaries, assaults and boosting/shoplifting more prevalent among males overall, especially those in San Diego and Honolulu, and among women in Honolulu.

* Dealing and Distribution: Over three-fourths of both male and female respondents reported engaging in drug sales and distributions connected to their use of methamphetamine. Women Dealers were substantially more likely than male dealers to be successful business entrepreneurs and were more likely to describe dealing patterns in terms of business ethics and pride, and rules for operation.

SUMMARY OF FINDINGS

Our research found methamphetamine use to be firmly entrenched in some communities, and is steadily spreading into new areas and populations, especially in California. In urban areas we found that many high risk behaviors are crossing boundaries. Rave and club scenes have become a nexus bringing together men and women from levels of society, both gay and straight, where meth is used and sold.

Results from the study in Honolulu indicate that ice is finding and uncomfortable but considerable position among other illicit drugs. The use of ice in Honolulu had led to particularly serious physical and psychological problems and significant social disruption in poor working communities where it replaced marijuana which had become scarce and expensive due to eradication policies. Ice continues to result in very serious individual problems contributing to the devastating impact on these communities.

Methamphetamine drug control policy has resulted in several unintended consequences. The first was that the reduction of available chemicals used to manufacture P2P meth encouraged its replacement by the ephedrine process of manufacturing. The chemical precursors for this process are not so difficult to obtain, it is somewhat easier to make and conceal. As a result many small independent labs have become more widely distributed throughout the state, manufacturing products of varied and unpredictable quality. Thus more users have easier access to more a potentially dangerous product. The growing population of marginalized working-class who are unskilled and relatively young from economically declining communities, also encourages entrance into the illicit methamphetamine manufacture and distribution industry.

Research findings suggest that greater amounts of less expensive meth from the mainland will be processed into ice in Honolulu, or on the mainland, leading to more competition with "Asian" sources, thus driving down prices and increasing the social disruption. Also, if increasing production of mainland methamphetamine promotes the importation of high quality "glass" into Honolulu, it will seriously increase the problem in both areas. A higher quality, much cheaper, and more available ice will increase consumption in Honolulu, and production on the mainland.

Disenfranchised communities, dysfunctional families and troubled individuals emerge as the most substantial contributing preconditions in providing access, interest and predictably problematic involvement with methamphetamine. The results from this study clearly show that methamphetamine is particularly seductive for poor people, and people with troubled backgrounds.

CHAPTER I.

INTRODUCTION

A. Research Aims

The overall aim of this study was to provide a basis for scientific inquiry into the growing and shifting problem of methamphetamine abuse, most particularly a new smokable variation known as "ice." This research examined a range of urgent and unexplored issues involving this drug among community-based samples in San Francisco, San Diego and Honolulu. Integrating qualitative and quantitative methodological strategies, data were collected from a total of 450 moderate to heavy methamphetamine users. Research goals centered around four central conceptual issues:

First, to uncover, examine and compare the rationale, context, and patterns of methamphetamine use among three diverse non-clinical samples of users;

Second, to chart the pattern of diffusion of methamphetamine use among our target populations accounting for both static and shifting patterns, motives, modes, amount and frequency of use;

Third, to examine the external and internal constraints which limit use, or modes of use, within all target populations, and to compare and contrast these constraints across a range of characteristics (user group, age, occupation, ethnicity, other drug use);

Fourth, to examine links between these issues to serious consequences: mental and physical health, financial, social, and criminal problems.

A final goal was to analyze these findings able to generate conceptual frameworks on the context and diffusion of methamphetamine use, characteristics of abuse, and potential influence on the overall drug problem in the United States.

B. Review of the Literature

1. Prevalence and Patterns of Use

There is substantial evidence documenting the increase in both the prevalence and serious consequences of methamphetamine use in the United States since the mid 1980s (Jaffe, 1989; Miller and Tomas, 1989; NIDA, 1989; NIDA, 1993). Information from a range of national data revealed that for much of the U.S., "methamphetamine abuse was becoming increasingly problematic" (Kirk and Miller, 1991:1). A National Institute of Justice Report documents an "explosive growth" in the use of methamphetamine especially in the western regions of the country. It also presents evidence that the problem is "spreading east." Increased methamphetamine trafficking is reported by law enforcement officials in New Mexico, Texas, Louisiana, Georgia, Arkansas, South Carolina and Massachusetts. In addition, this report presents evidence that biker gang activity related to methamphetamine distribution has spread to the mid-west, especially Missouri, Texas, Oklahoma and Tennessee (Department of Justice, 1989).

Prevalence continues to be greatest in California, which has also seen a dramatic increase in manufacturing, evidenced by an increase in seizures of meth labs from 352 in 1991 to 457 in 1992 (Brown, 1993). There is evidence that female use is increasing at a slightly higher rate than males (Pearce, 1993). Particularly alarming, are results from the latest NIDA survey of high school youth conducted by Johnson and colleagues which show a significant increase in amphetamine use among 8th, 10th and 12th grade students. Among high school seniors, the percentage reporting use of this drug jumped from 7.1 percent in 1992 to 8.4 percent in 1993 (Washington Post, 1994).

2. User Characteristics

Evidence from a variety of sources reveal methamphetamine to be prevalent in White blue collar populations (Currie, 1993; Heischober and Miller, 1991; NIDA, 1989; Prevention Pipeline, 1992). Studies of perinatal methamphetamine use found that these females users are predominantly white and of lower socio-economic status (Little, et al, 1990; Dixon, 1989; Gillogey, et al, 1990; Struthers and Hansen, 1992). There is evidence, however, of increasing and significant use among Latino populations in the Western U.S. and among Asians and Pacific Islanders in Hawaii (Morgan, 1993; Haight, 1993; Miller and Kozel, 1991)

Further, the research which has centered on Asians reveals significant differences among ethnic groups, although these contributions focus almost exclusively on alcohol rather than illicit drug use (Lubben, Chi and Kitano 1988; Kitano and Chi 1987; Chi, Lubben and Kitano 1989; Sue, et al. 1991). Studies which have examined illicit drug use among Asian Americans are generally limited to student populations (Newcomb, Maddahian, Skager and Bentler 1987; Skager, Frith and Maddahian 1989).

3. Problem Indicators

Data from numerous recent studies underscore the serious physiological and psychological effects associated with the abuse of methamphetamine (Derlet and Heischober, 1990; Ellinwood and Lee, 1989; Bailey and Shaw, 1989; Heischober and Miller, 1991; Nisenbaum, 1989). Also, studies of female users in California and Texas reveal high rates of methamphetamine use during pregnancy (Little, et al., 1990; Vega et al., 1993). Moreover, there is evidence that these problems are on the increase. Methamphetamine deaths, although on a lesser scale than heroin or cocaine, tripled nationally between 1985 and 1989 according to government statistics (NIDA,1990), In California, primary drug treatment admissions for methamphetamine related problems increased dramatically from 914 in the 1985/86 fiscal year to 9,348 in 1990/91 (Pearce, 1993).

HIV Risk Behaviors: Evidence from a nationwide sample of injection drug users reveal that over half (54 percent) reported using methamphetamine (NIDA, 1991). Among these, whites had a greater tendency to be lifetime users, to have injected the drug to have begun using at an earlier age. However, female injection methamphetamine users in this sample were more likely than their male counterparts to have injected in the last six months, and to have injected four or more times per day (NIDA, 1991). Recent California data identifying methamphetamine users in treatment reveals that the number of clients citing injection as their primary mode of use increased from 952 in 1986 to 2509 in 1990 (Pearce, 1993). In 1990, IV use accounted for 26 percent of all methamphetamine related treatment admissions state-wide, and for 67 percent of admissions in San Francisco (Pearce, 1993). Flynn (1991) reports that IV stimulant users in the Sacramento area as a whole are more likely to

engage in high-risk behaviors than IV opiate users, resulting in a HIV prevalence rate of 5 percent, compared to one percent for opiate users.

Problems of Ice in Honolulu: In the closing months of 1989, the U.S. mainland became aware of a new and potentially disastrous substance called "ice." Primarily imported from the Far East, this smokable form of methamphetamine continues to be a leading drug problem in Hawaii (Essoyan, 1989; Holmes, 1989; Lemer, 1989; Sager, 1990; Zurer, 1989). There is fear that "ice" could prove to be even more attractive and problematic than crack. Much of this concern stems from the longer duration of the high when compared with crack, with effects reputed to last anywhere from 4 to 30 hours (cf. Corwin, 1989; Holmes, 1989; Rothman, 1989; Tabor 1989). Treatment programs in Hawaii and San Francisco are reporting increasing cases of ice abusers showing severe physical and psychological problems following relatively brief periods of use (Kuipers, 1989; Thompson, 1989). An additional concern is the likelihood that domestic production of ice will soon replace the imported product in meeting increased consumer demand (Corwin, 1989; Kuipers, 1989; Sager, 1990; Zurer, 1989).

C. Significance of the Study Sites

This research study utilized this knowledge gathered from the literature to select those sites which each represented significant aspects of the problem. Consequently, this community-based naturalistic study examined and compared methamphetamine users in three sites: the greater metropolitan areas of Honolulu, San Francisco, and San Diego. Data is drawn from a sample of 150 moderate to heavy users in each area. These three geographical areas were selected for two reasons. First, there was evidence that the incidence of methamphetamine use and problems was substantially high in each site. From 1985 through 1989, there were 2,160 emergency room episodes in San Diego and 1,525 such episodes in San Francisco associated with methamphetamine use (NIDA 1991). In the period 1987 - 1990, it was reported that the smoking of meth in the form of ice had reached epidemic proportions in Hawaii (Hall and Broderick, 1991).

The second reason for selecting these three sites stemmed from evidence that methamphetamine use differed significantly in each locale. Studies of clients entering San Diego drug abuse treatment programs in 1990 showed that most (62%) of the methamphetamine use was intranasal. In San Francisco the primary mode of administering methamphetamine (reported by 66.5% of the methamphetamine users entering treatment) was injection (Burciaga Valdez, 1992). The methamphetamine form used most often in Honolulu is ice, a crystalline form of the drug that is typically smoked in glass pipes (Wood and Carlson, 1990).

Each study site is unique and presents different challenges and opportunities. The Honolulu site represented the first systematic research on "ice" users in the above communities, even though available evidence revealed it to be the major area experiencing increasing, substantial and widespread use of ice (or "batu") forms of methamphetamine. Primary user populations comprising Filipinos, Chinese, South East Asian, Hawaiians, Samoan and Asian and South Pacific Islanders, are among the least understood or systematically examined minority groups by social science research. Moreover, the context of methamphetamine use involves tightly knit cultural groups which are particularly difficult to access and study.

The San Francisco site targets user populations in San Francisco, Alameda and Contra Costa Counties. These areas combine both urban and semi-rural locales with a varied population of users.

Existing data suggest there is a high incidence of intravenous (IV) use among methamphetamine users in this area. However, almost all research on the prevalence of HIV infection among IV users focuses primarily on heroin and cocaine. In addition, the paucity of research since the limited studies resulting from the "speed epidemic" of the late 1960s highlights the need for systematic examination of long term users in this site.

The study site in San Diego includes the greater metropolitan area and communities in the eastern sectors of the county where there has been a high prevalence of intranasal methamphetamine use. This area also includes demographic groups never studied and very difficult to reach. Populations showing heavy and widespread use (often involving distribution and manufacture) include: young Caucasians of lower socioeconomic or working-class status, long-standing "biker" networks; and increasing use and distribution within Mexican populations.

D. Outline of Final Report

Findings presented in this report address the specific aims outlined above. As in the case with most exploratory, descriptive research the major goal has been to identify contexts, rather than search for specific correlations. However, we designed the study to include a systematic target sample strategy with a large enough sample size so that we could integrate measures and correlations where appropriate. We have structured the substantive material therefore to maximize both sets of data: quantitative and qualitative. The substantive content therefore is both theory driven and theory building. We have also attempted to balance the value of a clear structure, with the necessity of contextual overlap.

Chapter II presents a discussion of the basic methodological issues framing the research agenda and data collection process. This includes target sampling and instrument development, the use of focus groups, community consultants, other data sources and interviews. We also provide a detailed outline of our data management strategy and the ways in which it maximized both data collection and analysis. We follow with a discussion on both qualitative and quantitative data analysis. The chapter closes with a short summary on issues of reliability and validity as they relate to our study.

Chapter III of this report contains historical and chronological information on methamphetamine nationally and in each of our study sites. The first section begins with the promotion of pharmaceutical amphetamines beginning in the mid-20th century. It then chronicles the process of illicit methamphetamine use beginning with San Francisco in the 1950s, and covering the origins of illicit production which was located in this area. It completes its social history of the development of the San Francisco speed scene in the late 1950s through the 1960s.

The next section moves to the San Diego Area tracing it's roots as the "crystal capital" of the United States. It examines the relationship between outlaw biker networks, to isolated and disenfranchised white working class communities which became the center for "mom and pop" laboratories. The chapter then turns to Honolulu, traces the introduction of Ice, and its financial and physical transformations. The chapter closes with a description of the meth manufacturing process on the mainland.

In Chapter IV, we first present detailed information on each study site. The second section reveals findings on respondent characteristics, compares these across sites and by gender, defines

the major user types in each site, and common respondent characteristics found across all sites. The third section of chapter four presents data on use patterns and characteristics. This includes, length of use, role of other drug use, and issues involving modes of use in each site and by gender.

Chapter V presents findings on common individual antecedents found among users in our sample, and shared social antecedents which may have had an effect on contexts of early use. The following section presents data related to the initial and early phases of methamphetamine use among our sample. These include arena of initiation, motivations for initial use, first impressions from early phase of meth use.

In Chapter VI we discuss findings particular to the continuing drug careers experienced by our respondents. We explore and compare the differing rationales, routes and rules which account for evolving use patterns and transitions observed in our sample. We identify the significant transitions over the years in their usage patterns, modes, motives and contexts. We also show how meaning and value attached to the meth experience itself generally evolved over time along with a growing body of user folklore, rituals and rules to guide respondents.

Chapter VII examines findings on effects and consequences associated with prolonged and heavy use. It begins with both short and long term physical problems reported by our respondents. The second section presents data concerning the serious individual concerns and psychological effects which accompany heavy and prolonged use, beginning with a discussion on control, dependency and addiction. The third section centers on behavioral and social consequences, with special attention to pregnancy, child welfare, and HIV/AIDS risk issues involving high risk sex behavior, and IV drug use. The section closes with findings detailing criminal behavior patterns among our sample. The final section presents the consequences of meth use on the social ties: from intimate relationships and family, to problems with work, friendship networks, finances, employment, and finally a discussion on the negative impact meth has on already disenfranchised communities.

Chapter VIII focuses on issues of quitting use, and the impact of treatment and other interventions among respondents. It examines user reports covering motivation and rational for quitting, issues promoting and/or hindering their ability to quit, their quitting experiences, and how they view success. The chapter then goes on to provide a detailed analysis of the subsample of respondents who had undergone treatment for their meth use. This section examines pathways and barriers to treatment, along with respondent accounts of their treatment and/or intervention experiences.

Chapter IX reveals important findings on the level, extent and contexts of the major role our respondents had as dealers and distributors. It begins with a discussion of the important unexpected findings concerning the extent and leadership of our women respondents as major dealers and distributors of illicit methamphetamine in all three sites. It examines the links and differences between dealer and site characteristics, comparing men and women. The chapter then examines findings concerning dealer networks in Hawaii, and on the Mainland. This is followed by a descriptive portrayal of national and international distribution networks.

Chapter X attempts to draw these issues together by analyzing the major theoretical issues emerging from these data and discussing them in the context of what was previously known in the research.

CHAPTER II.

METHODOLOGY

The study developed an integrated qualitative/quantitative methodology designed to maximize the range and content of data collected and to enhance the internal and external validity of the findings. The sample consisted of 150 respondents in each study site. Selection criteria was based on the following: (a) use of methamphetamine as the stimulant drug of choice; (b) self identify as "moderate to heavy" methamphetamine users; and (c) regular use of methamphetamine within the 12 months prior to interview. Data were collected by means of an in-depth one to two hour taped interview, followed by completion of an extensive quantitative questionnaire.

A. Pilot and Development Phase

The study utilized a six-month pilot phase. This period was used to gain entre into populations never before studied, mainly involving communities in the Honolulu and San Diego sites. Two other primary objectives of the six-month pilot phase were to systematically compile and evaluate existing information on the patterns, prevalence and consequences of methamphetamine use, and to identify the range and characteristics of user groups in order to develop a comprehensive target population sampling design.

1. Target Sample Development

The targeted sampling design aimed to systematize chain referral methods in order to maximize representation among these hidden methamphetamine using populations. The success of this sampling method has been demonstrated by Watters and Beimacki (1989), and others (Kuzel, 1992; Biernacki and Waldorf, 1989). The research design incorporated an extended sampling development phase in order to integrate data from several sources: problem indicator data, community consultant and focus group interviews, and ethnographic field work. Triangulated analyses of these data established preliminary target samples, and identified major issues for the qualitative interview guide and questionnaire items.

Problem Indicator Data: Information was obtained from alcohol and drug program agencies, and included treatment and emergency room data, program evaluations, and client demographics. We also compiled data from other related research studies for potentially relevant information. In addition, information was collected from criminal justice sources, hospital discharge data sources, and from mental health and welfare agencies. Finally we kept records of all relevant periodicals and local newspapers.

Community Consultant and Focus Group Interviews: The preliminary phase employed focus groups to obtain detailed and ongoing information to determine the range, characteristics and significance of potential target populations of user groups. Approximately, 6 to 8 groups were held in each site. An interview guide was developed to gather information concerning (a) user demographic characteristics; (b) geographic location of identified user groups; (c) descriptions of user social worlds; (d) method and amount of use; and (e) price per gram/unit. (See Appendix A) These group sessions were taped and transcribed and the data analyzed.

During this period we recruited and interviewed Community Consultants. Our prior experience in the field underscored the extremely important role in exploratory community-based research on hidden populations. Commonly referred to as "key informants" in the enthographic literature, they were knowledgeable members of the population being studied: well informed about drug use patterns, helpful and articulate. They were in position to access specific population segments, broaden our study's network of contacts, and add to its credibility and legitimacy. They were also able to describe common aspects of behaviors being studied.

Community consultants for this study included a wide range of people, such as former or current drug users, service providers, or community activists. These community consultants assisted in identifying and provided access to the target population, and provided an important contribution to the development of the target sampling frame. They also provided feedback on the validity and gaps in the data collection instruments, and continued to consult throughout the project.

Ethnographic Field Work: The dynamic nature of exploratory community-based research framed the purpose of this component which was to explore key contextual patterns, identify key social user groups, and target primary geographical areas. Ethnographic fieldwork was undertaken by research staff, interviewers and by community consultants. Ethnographic field notes were compiled from a wide variety of social settings in each site and assisted in the development of the target population sample, the research instruments, and throughout the study.

2. Instrument Development and Pilot Testing

Information compiled in the first six months was used in the development of both qualitative and quantitative instruments. Senior research staff analyzed and integrated this information, met to construct draft instruments, and pilot tested these instruments among a sample of methamphetamine users and community consultants in each area. The results were analyzed and utilized in revising data collection instruments.

B. Data Collection

Data collection comprised a taped in-depth interview lasting approximately two hours followed by the administration of a questionnaire by the interviewer. Data were collected by trained interviewers who were both familiar with, and known by the community. Interviewers, along with the senior research staff also conducted ethnographic field research, and held regular meetings with community consultants to assess validity of findings, and to provide current information on changing dynamics in the population relevant to the study.

1. Qualitative Data Collection Instrument

The qualitative instrument consisted of an open-ended interview guide administered by a trained interviewer in a taped interview format. (See Appendix A) This took the form of a life history, utilizing conceptual information gained in the preliminary studies discussed above. Each qualitative interview lasted approximately two hours and elicited detailed descriptions covering the following: background history and experiences; alcohol and other drug use history, patterns and context of meth use over time; rationales and motives for use; high risk behaviors associated with use; adverse consequences of use; perceptions of meth use problems for self and community; characteristics of

interpersonal, social and family relationships; impact of use on these relationships; perceptions of social well-being; employment, and criminal experiences.

2. Quantitative Data Collection Instrument

Quantitative data were collected by means of a close-ended questionnaire administered at the conclusion of the taped qualitative interview. (See Appendix A) The quantitative instrument included questions in the following areas: demographic characteristics; employment and other forms of support; family and childhood background; parental use and problems with alcohol and other drugs; physical and mental health histories; personal alcohol and other drug use history, including patterns and problems; methamphetamine histories including motivations and contexts of early use; evolving patterns, transitions and consequences of use; physical, psychological, employment, social and criminal problems associated with use; treatment history; sexual and other high risk behaviors for HIV/AIDS; and legal history. In light of the tremendous ethnic diversity in Hawaii, we included additional measures of ethnicity and cultural identity to the questionnaire.

Questions related to the respondent's personal drug use history were recorded on a drug history chart contained within the questionnaire. After the interview, the interviewer transcribed the responses listed on the drug history onto "the drug history code book" which provided a user friendly format for data entry.

C. Data Management

The data management utilized in this study was designed to maximizes the researchers ability to efficiently and quickly respond to incoming data, apply necessary sample modifications, and incorporate emerging and dynamic issues into the data collection instruments. This involved several components.

1. Interviewer Research Staff

The selection of interviewers were required to meet several basic criteria which included: good social skills, an ability to build rapport with potential respondents, and extensive experience with the social worlds of methamphetamine users in our target population. They were also required to have a foundation in academic skills, including a knowledge and understanding of research goals and writing ability. Interviewers were required to complete a comprehensive training involving learning interviewing techniques and skills for both qualitative and quantitative components; background information on the nature and significance of the problem; issues involving human subjects and confidentiality; and a comprehensive understanding of the purpose and design of the research project. They were required to complete a mock interview in the presence of the project director who provided feedback and suggestions for improvement. Interviewers then underwent a probationary period, requiring a full analysis of the first five transcripts by the project director. Finally, project interviewers were also included into all components of the research enterprise. They attended regular staff meetings, and contributed their knowledge to the ongoing research and analysis.

2. Quantitative Data Management

Upon completion of each interview, the quantitative schedule was checked for completion and

coding accuracy by the interviewer and staff at the field office. The instrument was also checked when forwarded to the main office by the administrative staff and by at least one of the research investigators. During the manual check of each quantitative packet, logic checks were performed on key variables (e.g., drug use levels) to detect possible inconsistencies. When inaccuracies, inconsistencies or missing data were present, interviewers were contacted immediately to clarify and correct potential errors.

Once this verification process was completed, quantitative questionnaires were sent in routine batches for data entry into a Statistical Package for the Social Sciences (SPSSX) data base (PC version) at the San Francisco office. A total of 280 variables were entered into the data base for statistical analyses. Frequency distributions and logic checks were performed routinely to detect and clean data entry errors. We conducted a final verification and editing of the data set after all 450 quantitative interviews were entered.

3. Qualitative Data Management

All interview tapes were listened to before transcription. This was important for several reasons. First, because hearing the interview and its ambiance is very different than reading the transcript, the researcher was able to identify nuances missed in the transcription process. Second, it provided immediate feedback to interviewers, especially for quick follow up information--going back to respondents for additional material or clarification. Third, it maximized the potential for detecting and processing emerging data. Finally, it enabled the project director to "triage" all interviews, rating the priority of transcription for seminal interviews, topics, new groups or phenomena. Our feed-back system from the field to the staff, and back to the field became substantially more efficient, enabling the project director to update and "train" the interviewer on a continual basis--to maximize their interviewing skills, to follow through on certain "chains" or groups, to enlarge the open-ended questions, and to systematically incorporate their feedback into the sampling and analytical process in the field.

The study also collected current demographic information in each site by utilizing data from the "quick reference sheet" developed especially for this study. (See Appendix A) This sheet was completed by the interviewers at the time of the interview and contained the most important demographic information plus summaries of major substantive issues, such as health status, drug use history, social networks, etc. This information was entered and updated on a daily basis allowing the staff to maintain current information on the population.

D. Data Analysis

1. Qualitative Data Analysis

The basic purpose of qualitative data analysis was to systematic interpret, analyze and give meaning to the individual's perceived reality in the context of her/his social world. The validity of any theoretical analysis lies in the validity of the conceptual tools used to build that analysis. Consequently, the aim was to employ analytical methods framed by the "grounded theory" procedures developed by Glaser and Straus (1967). Thus data from the interview transcriptions were continuously analytically coded by the research staff from the beginning of data collection. The data were coded for salient dimensions, constellations of basic numerical, social, social-psychological and structural processes are discovered, and entered in the computer.

While coding, theoretical memos were drawn from the data and analyzed by the research staff. The memos varied in length and often contained direct quotes from the interview which illustrated basic findings in the qualitative data. Theoretical memos were entered in the computer, and filed according to the code to which they corresponded. This process helped to clarify emerging issues in the analysis. and thus fulfill the primary goal of an exploratory study. The discovery of new and potentially relevant issues during the process of data collection, enabled the research staff to add them to the interview schedule.

2. Quantitative Data Analysis

Because the quantitative interviews were entered into a PC database, we had ready access and an efficient means by which to continuously monitor and analyze incoming data. Throughout the data collection process, we routinely conducted analyses of the demographics of our respondents, their drug use histories and associated problems. These analyses were done to determine whether sampling targets were being met and to determine whether distinctive patterns were emerging in each of the three sites. Given the exploratory and qualitative nature of this study, our primary analysis in this report relies on descriptive, summary statistics, and where appropriate (e.g., cross site comparisons), tests of statistical significance.

E. External and Internal Validity

1. Internal Validity

Validity of questionnaire data was assured through a process of multiple verification. All coded responses were checked by the research staff in each site, verified again by the administrative staff at the central office, and given a final check by a senior research investigator before being sent to data entry. Frequency runs at regular intervals were also checked by senior research investigators for possible errors in data entry.

The study tested the veracity of respondents in several ways. First, all of our interviewers had extensive experience with methamphetamine users, and were matched according to their knowledge of particular user groups. They often came from the same neighborhoods as the respondents, shared familiarity with common sub cultures and/or networks, understood local dialects and terminology, and at times had previous ties to respondents, or to their circle of friends or family. Consequently, interviewers were able to detect bogus information. Most often, interviewers were able to correct the situation in the field and obtain valid data. When this was not possible, the interview was considered invalid at the field site. Secondly, the project director and the transcriber both evaluated respondent veracity in the process of listening to the audio tape. Third, a large proportion of information was gathered by means of both the questionnaire and the depth interview. Usually, interviewers were able to address any discrepancies at the time of the interview, and always noted them in their summary statements.

2. External Validity

The study was able to verify findings through a triangulating process of confirmation. To guard against biases toward an overemphasis on pre-existing expert or scientific knowledge, we regularly presented emerging data to individual key informants, and focus groups of users and ex-users in appropriate subcultures. To guard against "going native," we maintained regular and close contact with knowledgeable clinical, and research consultants. Additionally, emerging findings were assessed by "community consultants" in each area. Finally, research staff, senior investigators, and community consultants contributed ethnographic field notes covering crucial subcultures, events and "scenes."

CHAPTER III.

EVOLUTION OF METHAMPHETAMINE USE, DISTRIBUTION, AND MANUFACTURE

A. Introduction

This Chapter explores the emergence and evolution of clandestine methamphetamine use, distribution and manufacture in California and Hawaii over the past three decades, focusing on: the San Francisco Bay Area's role in the origin of illicit methamphetamine labs in this country; San Diego County's major role in the 1980's in increasing the production of the ephedrine reduction type of crystal methamphetamine; and Hawaii's unique role in bringing a new dimension to methamphetamine use via a completely different distribution route. We start with a brief chronology of pharmaceutical methamphetamine and its use in the U.S., followed by an analysis of the evolution of distribution and manufacturing patterns.

B. Pharmaceutical Stimulants

Methamphetamine is a member of a large family of stimulant substances. Although they are somewhat different, they share many of the same chemical properties and are often confused. Generally, the most used and popular pharmaceutical pills and capsules are called "amphetamines" by law enforcement and illicit users alike. As the most common basic types found their way into the illicit marketplace they took on "street" names as well.

The most sought after and long lasting high comes from methamphetamine and is the only speed manufactured to any significant extent in clandestine labs in the U.S. Illicit methamphetamine is almost always described by a different term, such as; meth, crystal, crank, etc. The term "meth" stems from the most popular brand-name Methedrine. All the stimulants, including amphetamine and methamphetamine, are often lumped under the generic term "speed." A clarification defining the terminology used for these stimulants is found in Appendix B.

2. Pharmaceutical Stimulants in the Legal Marketplace

First synthesized in 1919, methamphetamine became known by its brand name methedrine. In the United States, the FDA approved the use of benzedrine, dextroamphetamine and methamphetamine for various medical reasons in the 1930's. Although methamphetamine was employed in clinical practice in the 1930's in Germany, and found widespread use as a stimulant among Axis forces during W.W. II (Spotts and Spotts, 1980), it was the amphetamine drugs which first became popular in the United States. Amphetamine tablets could be obtained without prescription until 1951, and amphetamine inhalers were available until 1959 (Griffith et al., 1970).

Throughout the 1960s, between 85 to 90 percent of the more than 20 million prescriptions written each year for amphetamine compounds were for weight reduction (Ellinwood, 1979; Spotts and Spotts, 1980). The following description of Desbutal in the 1964 Physicians' Desk Reference (PDR) illustrates other reasons why millions of Americans consumed an estimated 8 to 12 billion doses of licitly manufactured amphetamine annually throughout the 1960s.

...feelings of depression are overcome and a sense of well-being and increased energy is produced. Inner tension and anxiety are relieved so that a sense of serenity and ease of mind prevails. (Physicians' Desk Reference, 1964: 506).

As with other amphetamine compounds available at the time, this commonly prescribed combination of Desoxyn (methamphetamine hydrochloride) and Nembutal (pentobarbital sodium) was portrayed as a panacea for a host of mental and physical problems. To understand how and why millions of Americans were able to consume such a formidable supply of pharmaceutical amphetamines, one need only review the plethora of acceptable indications found in the Physician's Desk Reference (PDR) and other prescribing manuals (Grinspoon and Hedblom, 1975; Spotts and Spotts, 1980).

Legal production soared from approximately 3.5 billion tablets in 1958 to 8 billion tablets ten years later. The number of prescriptions continued to rise until 1967 when 31 million were written. Ellinwood (1974) estimates that 6 to 8 percent of Americans over the age of 18 could have been prescribed one of these amphetamine compounds during that year. These percentages were significantly higher among younger adults and those living in various regions of the country. This was particularly true for San Francisco, where one study found that 17 percent of women and 7 percent of men between the ages of 18 to 29 had reportedly taken stimulants prescribed to them during the past year. They found that this sex differential completely disappeared, however, when taking into account the additional 17 percent of the young males compared with 6 percent of the females who reported taking prescription stimulants obtained through nonmedical sources (Mellinger, Balter and Manheimer, 1971).

There was ample evidence of the considerable diversion of pharmaceutical amphetamine compounds throughout the 1950s and 1960s. Despite the considerable demand exerted by the millions of prescriptions written each year, pharmaceutical amphetamine production continued to grow at a rate far beyond that needed for solely medical purposes. Until strict production quotas were finally established in 1971, pharmaceutical companies were producing an estimated 100,000 pounds of amphetamine each year (AMA, 1966), divided between almost 400 separate brand names produced by over 200 loosely monitored independent manufacturers (Shulgin, 1975). Researchers estimated that one-half to two-thirds of this amount was diverted to black market channels (Byles, 1968; Graham, 1972; Grinspoon and Hedblom, 1975).

In the late 1950's some well-meaning physicians tried IV administration of methamphetamine as a treatment for heroin addiction, (and others prescribed "Dr. Feelgood" shots for depression, or dieting). Less well-intentioned "scrip" doctors profited by prescribing liquid methamphetamine ampules to those who would pay the price. The combination of these and other access routes led injecting methamphetamine to become a popular addition to many illicit drug users' repertoire. The most prevalent of the injectable ampules were made by Abbott (Desoxyn) and Burroughs Wellcome (Methedrine). By the early 1960's the San Francisco area had a sizable group of drug users who had become committed to IV methamphetamine.

The widespread diversion and dispensation of "jugs" to local addicts by particular doctors and pharmacists eventually came to government attention. This trend led to government intervention with the drug companies and the withdrawal of injectable methamphetamine ampules from the market. When over 500,000 ampules were prescribed in just the first half of 1962, the era of easy access quickly came to a halt (Brecher, 1972; Smith, 1969). At the California State Attorney General's request, pharmaceutical manufacturers voluntarily removed methamphetamine ampules from the

outpatient prescription marketplace (Spotts and Spotts, 1980). Abbott withdrew Desoxyn ampules in 1962 and Burroughs Wellcome did the same with liquid Methedrine in 1963. This left a void which set the stage for the development of illicit methamphetamine manufacture.

C. San Francisco Bay Area

1. Diverted Methamphetamine Use

In the 1950's heroin users found diverted pharmaceutical methamphetamine to be a readily available and cost-effective substitute for cocaine which was injected with heroin in the "speedball" (Rawlin, 1968; Smith, 1969). A 60 year old respondent whose use history stretches back to the mid-1950s fondly recalled this particular time period. She described her reaction to this new combination:

> *I loved speedballs. Cocaine and heroin was great. Crank and heroin was wonderful. Too grand! Two great things at one time! (026)*

A longtime African American user recalled his initiation into what he called "the kingdom of speed" during this time:

> *I was over on Bush Street in 1958 ...they had ampules of Methedrine and called them "Jugs." I was involved with a woman who was a dancer in North Beach and I had been "skin popping" heroin but I'd never mainlined. This woman changed my mind and it was a memorable experience. She hit me in my arm with meth and I dropped to my knees. The whole room looked like it did a flip over. It scared me cause it felt so good. God, it felt good. The both of us didn't go to work that night. We bowed down to the great God of speed! I've been worshipping ever since. (071)*

When a small number of well-meaning physicians in the San Francisco Bay Area began to prescribe methamphetamine ampules to heroin addicts things began to change. One of these was a longtime bohemian female respondent who recalled the outcome of this "treatment" for the an addict population suffering from a prolonged heroin drought:

> *This was in about '57 or '58. It became a rage. A doctor helped us and said she could help drug addicts get off heroin by using this methamphetamine. She said it also took care of dealing with the tiredness of having hepatitis ... She thought she was the angel of mercy come to help the heroin addicts. She was a marvelous woman. She couldn't believe what happened, she couldn't believe the same people three years later. She did it for good; she gave outfits so you had clean works. She tried, she meant well. It wasn't money at all. ...other doctors started after her but they did it for financial gain. (026)*

This fascinating respondent actively participated in the "beat" circles of the time, "hanging-out" with Lenny Bruce, Jack Kerouac and other notables. Very much an insider, she described the widespread interest and use of methamphetamine among this population:

It was a party drug. It was a wonderful thing to share your drugs with your friends. When someone came to your house, just like getting coffee, you offered an "amp" ampule. It was a social thing. It wasn't considered bad form to have a drug party with the artists, they'd share their paints. No one sat around watching TV then. You sang, you drew or painted, wrote poetry, novels... I am a special part of Kerouac's book, [laughs] he told me I'd be pleased. (026)

When her husband went to prison she developed a variety of money hustles. She had a sporadic singing career, engaged in prostitution while running a "Call-House," and made money with drug selling scams. Especially profitable were the ones she was able run for Desoxyn ampules between 1957 and 1962. To accomplish this, she sought out a "scrip" doctor willing to prescribe liquid methamphetamine ampules to anyone who would pay the price:

He'd take all the addicts and I would pay him a blanket monthly rate for his continued refills for them ... No more traffic in and out of his office, he'd give me all the refills for the month and I'd pay him a flat sum ... The refills went on, and I filled them at certain pharmacies that gave me good rates cause I did so much business with them. They didn't even know what to think about these ampules at the time, they jingle-jangled when you walked, they sounded like toys in people's pockets.

... Then, I began to see people in three piece suits go funny. They all had access to speed and it was still legal or you could get it. They began to stay up for days and pull bugs out of the air. I started feeling a little guilty about what I was doing, people couldn't stay up for days. They thought they were superman. They didn't have to eat or sleep ... but I was also excited about the money that was coming in, too. (026)

She believed that the high quality of pharmaceutical methamphetamine was an important factor in keeping the abusers from self-destruction:

Very good, excellent, it was clean. That was the only reason some of those people were saved cause it was clean. I don't think they could do what they did then, now on crank. I think they would do themselves in. At that time, it was already made up for you in ampules and hygiene was perfect. Sterile. You didn't put your fingers in it. Oh, my. It was nice. It was spectacular! There wasn't the anxiety in the drug that is there now. It was smoother. If you can imagine the best high you've ever had, imagine it smooth. (026)

2. The Origins of Illicit Methamphetamine Production

The withdrawal of pharmaceutical methamphetamine ampules from the market left a void for these users. Confirmed injectors had become dependent on finding their methamphetamine in ready to inject form, and they disliked the process of melting down pills and separating out the fillers and binders - which sometimes gave undesirable reactions when injected. Also, regular users were reluctant to spend the time and money required to use shady "scrip" doctors, or to track down dealers for expensive diverted methamphetamine pills. This created a market for an inexpensive water-soluble powder which lead to the creation of the first illicit "Bathtub" methamphetamine labs, in late 1962, to satisfy that demand. The same year that ampules were removed from the market, the first illicit methamphetamine labs emerged in the San Francisco Bay Area.

Phenyl-2-Propanone and methylamine (known as P2P) were the original basic precursors for the early illicit methamphetamine production. It became known by many street names, some of the more popular terms are: crank ("bathtub or biker crank"), peanut butter, prope-dope, and wire. This synthesis is claimed to have been originated by several groups from the early sixties. A few legitimate chemists apparently helped some small groups in the San Francisco area create this racemic combination of d and l isomer methamphetamine.

a) North Beach--Bohemians and Dope-Fiends: Our peripatetic bohemian/beat "ampule lady" very clearly remembered what she believed to have been the first clandestine "bathtub methamphetamine" lab:

> *The 1st lab I knew of was in a flower shop and the crank was truly made in a bathtub. It was on Hyde Street it was the first illegal lab in the city. I had to tell them to use wet blankets to cover the doors and windows so the smell wouldn't come out. The old Chinese opium smokers I knew taught me this trick. They used wet blankets to cover the doors so smoking opium was not discovered, it hid the smells. (026)*

This state of affairs would change in subsequent months as the speed epidemic in the Haight and elsewhere generated attempts to control clandestine production. This same woman who had assisted the initial bathtub operations by recommending wet blankets for the odor observed:

> *After a while the chemists found that they had to manufacture crank away from the city ... in the country, up in the hills, 'cause the smell was so bad, people would ask questions. (026)*

She also noted the significant role played by North Beach area beats:

> *North Beach always had a drug thing. The Fillmore also had a drug scene, but speed really came out of North Beach, it was hot there. (026)*

b) The Fillmore and beyond--African American Involvement: Unlike today, there was considerable African American involvement in all facets of the methamphetamine trade during these early years. During the 1950s and '60s, African-American users could be found in the beat scene as well as particular working-class user groups located in certain areas of San Francisco. And they made the transition to the sixties.

> *In 1964 I was already using speed from the Black part of the speed world, Johnny Duke's off the Haight and Fillmore. They had what they called "Black speed" or "chicken crank." It was sulfate, yellowish and it knocked your head on the ceiling! Whew! Just a little bit of it! You got jolted by it! (071).*

This African-American respondent, now in his late fifties, quickly mastered the cooking process early in the game. He managed to avoid trying his own product for over four months before eventually succumbing to temptation:

> *My brother was doing my dope, said it was good! So, I tried some... I.V. I made some crank and it was late at night, I was tired as hell! Brother said try it, it will wake you up! I tried it and it created a monster! ...I knew that it was my high, I liked it. (043)*

The growing number of cooks entering this new and highly profitable field came as no surprise to this African-American pioneer manufacturer:

> *I taught a lot of people how to cook, they were no competition to me. I sold all the drugs I made, I couldn't make enough. I'd cook two days a week, that left me five days to party. If I took a lot of speed, those five days became like 10 days - five extra days. I bought some property here in San Francisco, at one time, I had three houses in the City. (043)*

This same manufacturer said he sold to:

> *... white folks in North Beach, black folks in the Hunter's Point projects, whites in the avenues, and down the Peninsula, black folks in Oakland and Richmond, and white bikers in San Francisco and the East Bay ... I sold to everyone. (043)*

Drug enforcement efforts during this early period was very lax. A salient example of this is described by a cook who recalled:

> *Nobody knew what it was, I remember '66 in San Francisco when the police came, I had over one lb. of drugs in a shaving kit type thing, the cops put it in the sink and ran water over it, they said it was nothing but crank. [laughs] They didn't want to deal with it. (043)*

c) The Haight--From "Acid Heads" to "Speed Freaks:" During the 1960's speed use spread to a variety of groups throughout the SF Bay area. The most notable appearance of street methamphetamine in terms of wide usage, media attention, and public visibility was in the Haight/Ashbury. The media drew hordes of youthful idealists seeking the magic of psychedelics and the promise of utopian dreams. Ill prepared for the hard times to come, they possessed few inner resources to fall back on when this experimental life became difficult. Drifting from crash-pad to crash-pad, they found "going with the flow" to be difficult. In the process, the Haight rapidly turned into an crowded arena of confused or lost souls. Matters were made worse by predatory individuals who preyed on this naive population. Many of these young people became attracted to the feelings of strength offered by speed, or to the insulating effects provided by heroin and other depressants.

In this vulnerable setting, the number of rip-offs and other forms of exploitation escalated, life in the Haight deteriorated into an ugly street scene. Some saw the brutal tactics employed by local law enforcement as adding another element of repression and fear. (Smith and Luce, 1970). On the other side of the law problems arose when biker clubs began competing for dealing rights.

By 1965 outlaw bikers had discovered that they not only enjoyed methamphetamine, but could make money by setting up cooks to produce speed (crank was their term) and distribute it. Encouraged by the media, and word of mouth, bikers went to where the action was, the Haight, bringing crank with them to sell retail, and to supply local dealers. The "white-trash-punk" set overlapped with the flower-child scene and the bloom withered. This unfortunate convergence sealed the fate of the psychedelic experiment in that area, and by the late sixties the Haight had turned into a violent and squalid place. During this period, when the IV use of speed was becoming endemic, the phrase "Speed Kills" became the local mantra, displacing "Peace and Love."

The reasons for the withdrawal of black users and chemists from the speed world in the late 1960's and the early 1970's is complex and not well understood, even to our black respondents. One

could hypothesize that the stigma of a "white-trash" drug, or a "white-racist-biker" drug was significant, but for whatever reasons, most blacks faded out of the methamphetamine picture and cocaine became their stimulant of choice.

Other individuals continued to use methamphetamine in the late 1960's and into the 1970's, such as some of the now scattered bohemians, a few middle-class users, and college-students, but as time went by many of these users dropped away from methamphetamine use, once again for unclear reasons. Perhaps because they had less access to distribution networks, encountered poor quality crank, and also feared the above mentioned "white-trash" stigma. A few independent drug users stayed with "meth," but most drifted toward cocaine as their stimulant.

3. Bikers and Crank Distribution [1]

While the outlaw-biker love affair with speed extends far back into the pharmaceutical pill era, for many methamphetamine use came with the first illicitly manufactured meth. Our respondent who witnessed what may have been the first bathtub methamphetamine lab recalls:

> *... bikers started using crank in 1963, but they weren't big into the scene until they realized there was money in it. (026)*

Most bikers found that "snorting crank" was much more to their liking than swallowing available amphetamine pills. "Crank" became regarded as the best speed for the biker lifestyle, which emphasized fast, high-risk motorcycling, fighting, heavy drinking, partying, and barbiturate use. Bath-tub crank gave them the confident exuberance one user described as:

> *... feeling like superman, heavy rushing, speeding, courage and long-lasting power ... cranked up all the way. (102)*

Although illicit methamphetamine was used by a wide variety of groups in this period, the affinity of bikers and their lifestyle for the drug soon led to their increasing involvement. It didn't take long for bikers to realize that there was also big money to be made in the distribution and sale of crank. By the mid and late 1960's, biker clubs had become the dominant distributors of methamphetamine. This, in turn, led to wider social and geographical diffusion, and created the beginning of a major change within biker-clubs: they were to become large, and sophisticated money-making organizations rather than simply outlaw, party-time clubs.

In the 1960s most speed cooks were not color-wearing members, but were associated with the club, and paid like contractors. They were supplied with the kitchen and all the ingredients for the batch, and after a time these cooks became, in effect, members of the club. The clubs kept such a

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[1] *Notoriously difficult to get clear information on, hardcore biker clubs have developed many effective strategies to eliminate infiltration by observers or possible informants. Wolf (1991) illustrates the dangers of both penetrating Biker-Clubs, and then of extricating oneself unharmed. Similar constraints were faced in this study. We had little expectation of getting much information, but we were persistent and fortunate. Most (not all) of our biker (or ex-biker) respondents insisted that we not divulge any information that they considered traceable, and we have taken considerable precautions to insure this.*

strong presence during any cooking that the chef, in effect, belonged to them. At times the clubs would farm out production to people who did not have close ties, but they made it clear that they could not be crossed. Eventually some of the club members learned the ropes, and some of the cooks joined the club, so for a period of approximately 10 years they had close to a monopoly on all large-scale crank manufacturing and distribution.

The most ambitious biker group was the Hells Angels, whose mother chapter in Oakland was established decades ago. Adding to their burgeoning LSD sales, the "H.A." quickly immersed themselves in the California methamphetamine trade. By the mid-1960's, the Angels were already tightening their ranks and discipline in attempting to create a more powerful and invulnerable "structure resembling that of La Cosa Nostra" (U.S. Department of Justice, 1989:31). Chapter organization proceeded in a manner which sought to deflect law enforcement meddling while pursuing the dividends of the growing illicit "crank" market.

Outlaw-Bikers expanded their sphere of influence further during the late 1960's and the early 1970's. Biker-Clubs and the Aryan Brotherhood are said to have formed an alliance which changed the character of the clubs, and increased their methamphetamine distribution in Southern California (where the Aryan Brotherhood held sway). From the late 1960's onward, club members were spending more time in prison due to their increased drug trafficking, their high visibility and law enforcement's efforts against them. Bikers and Aryan Brotherhood members tended to merge loyalties in the racially polarized penitentiaries, which had the effect of increasing the racist attitudes within outlaw biker clubs, and also widened the influence of both groups, in and out of prison. (The preceding information came from two unrelated and very secretive ex-biker/ex-convict interviews.)

Biker distribution of crank worked its way into the semi-rural and rural populations of the San Joaquin Valley, Sacramento and Stockton cities, south down Highway 99, and the Interstate 5 corridor, through Los Angeles and San Diego. Their routes also traveled north through Redding and up to Oregon and Washington. These areas previously had small local user groups, but the wider distribution was generated by biker networks. Large-scale manufacture of methamphetamine made rural California areas to the east of the coastal strip favored lab sites all the way to the Mexican Border. Biker clubs from different areas fought over territorial rights to distribute drugs, and occasionally created temporary alliances with other clubs across the country, as far as the East Coast of the U.S., and of Canada. During this period biker clubs dominated and controlled almost all manufacturing and large-scale distribution of methamphetamine. The Pagans, Outlaws and Banditos did not go unnoticed as a U.S. Attorney's report to the President singled their drug trafficking as major among an estimated 500 outlaw biker groups (U.S. Department of Justice, 1989). However, top praise was reserved for the Hells Angels in recognition of their ruthless efforts:

> *... to control the clandestine manufacture of methamphetamine, an activity in which they are both highly skilled and highly influential. The Hells Angels has grown to become the wealthiest and most powerful of the outlaw groups. (U.S. Department of Justice, 1989:31).*

D. The 1980s: Ephedrine, Control and Distribution Changes

During the 1980s, there were a number of developments and transitions which, when combined, had a direct impact on the character of methamphetamine distribution.

1. Control Factors

In conjunction with heavy F.B.I. enforcement effort directed against the biker-clubs, and the increasing dissemination of the "new" ephedrine reduction method of cooking methamphetamine during the early 1980s, seemed to open up the market. This combination hamstrung the bikers and enabled networks outside "Club Affiliation" to function. In addition, because of bikers' earlier draconian attempts to control the product, several existing manufacturing groups wanted to drop their affiliation, in effect going underground from bikers as well as the law. The smaller of these groups became the so called "Mom and Pop" operations, groups of friends or family cooperating to produce small amounts of crystal in low-tech labs.

> *...there's white supremists in Arizona distributing, we've got bikers in certain parts of Califomia. But its becoming more independent 'cause bikers...they're no longer so interested in this type of business...it's becoming more and more mom and pop. (C C #6)*

2. Reduced Biker Dominance

After making considerable monies by the mid 1970's, biker-clubs diversified their activities to include several "straight" businesses, such as motorcycle shops, automotive repair shops, and bars, which served as money laundries. A Number of our respondents say that they also became active in gaming, protection, and other racketeering endeavors. As this diversification took place the manufacture and distribution of methamphetamine became less central to the biker economy (although it remained an important ingredient) and, together with the FBI crackdown, helps explain why bikers slowly relinquished some of their dominance in Califomia with less struggle than may have been expected.

3. Transition to Ephedrine Reduction Process

The anti-precursor actions taken by narcotics control agents, aimed at P2P production, had the unintended effect of encouraging a transition to the Ephedrine Reduction Process. As law enforcement efforts beginning in the early 19702 made the precursors for P2P harder to obtain, illicit chemists turned increasingly to ephedrine and the ephedrine reduction process. This became the predominant method of methamphetamine production on the West Coast. By the late 1980's it accounted for 80 to 90 percent of illicitly produced methamphetamine (NIDA, 1989).

Our more knowledgeable respondents assert that this is a cleaner and slightly easier-to-cook product, which reduces somewhat the pungent fumes generated during the manufacturing process. Our cook respondents emphasize that there are still considerable chemical odors generated while cooking. In its most highly desired form it is referred to as "glass, crystal, ice, or sparkle." Ephedrine reduction produces the D-isomer methamphetamine which is found in pharmaceutical methamphetamine (e.g. Desoxyn). The D-isomer is three to four times as potent in eliciting CNS stimulation when compared with the L-isomer (Morgan, 1992).

E. San Diego: the Making of the "Crystal Capital"

1. Background/History

San Diego's early stimulant history was less active and evident than the San Francisco area's well documented speed scene. Previous to the 1960's there is little or no reference to a stimulant

problem in San Diego, but during the sixties there was considerable smuggling and dealing of so called "speed" pills from Tijuana. "Bennies" ("white crosses"), dexamyl, and Desoxyn, (among other stimulants) were purchased in pharmacies across the border and brought in to use and sell. One respondent reported:

> *We were IV users in the sixties, we bought desoxyn in Tijuana in pill form, there was no powder methedrine available. (225)*

The late 1960's is the first period in which a form of crank is mentioned. Called "Peanut Butter Crank," it was being manufactured and distributed by outlaw biker clubs. Biker crank was used by bikers and their associates and it did not spread widely. As one respondent said:

> *The speed industry in San Diego used to be controlled by the bikers, the "bathtub crank" they were making it. In those days it was strictly motorcycle gangs. (201)*

The limited popularity of methamphetamine waned in San Diego during the early 1970's as cocaine became the leading stimulant of choice, and it wasn't until 1980 that ephedrine-based "crystal meth" started to make inroads into a wider population, especially in East San Diego County.

2. The "Bogota" of the U.S.

Sometime around 1980 big money players got involved with manufacturing methamphetamine of the ephedrine type. Crystal meth began to diffuse rapidly around the county particularly in the eastern areas like El Cajon. Young, working-class whites took to the long acting, inexpensive methamphetamine through-out the eighties, until San Diego became known as the "Bogota" of methamphetamine in the U.S. Labs were found all over east San Diego, and many eventually moved out to the desert, including Arizona and Nevada.

In San Diego the biggest and most notorious group of manufacturers were the Battaglia Brothers. Before the federal prosecutors closed in on the Battaglias (Jack and Manuel) they had expanded into money laundering businesses in San Diego, Reno, and elsewhere, and "factions" had been created, such as the Rupley group from Sparks, Nevada, and others. Only after long investigations were arrests made and charges filed. The first indictments were in 1987, and the Battaglias were finally sentenced in 1992. Jack Battaglia got 29 years at the age of 50, his brother, 20 years.

Another, ironic, source for methamphetamine manufacturing was the now infamous "Triple-Neck" sting operation, which supplied cooks with glassware, and precursors (essentially equipping and stocking their labs.) for many months in 1989, and which inadvertently allowed large amounts of crystal to be made and sold before arrests were made. (Triple-Neck refers to the three funneled glass flask which was the centerpiece of the glass equipment necessary in the manufacturing process.) Several of our respondents alleged that a goodly number of triple-neck "customer-cooks," having bought all their supplies there, had made and sold their methamphetamine, and vanished from sight before any busts were made.

At the smaller end of the manufacturing spectrum, San Diego County also had many "Mom and Pop," labs. These were often a few friends, or a family, who got together to produce crystal for their own use, and to sell on a small scale, in order to pay their drug costs. They lived at only slightly above subsistence level, rather than at the high-flying style of the big operations.

Today San Diego is an extremely active county for methamphetamine use and distribution, although respondents report that much large-scale manufacturing has reputedly moved to other areas, such as over the Mexican Border, San Bernadino County, and other California counties.

F. Honolulu – Ice

Ice in the U.S. is found predominantly in Hawaii (most particularly in Honolulu and its environs) where current methamphetamine use is almost exclusively limited to ice. Ice was developed and distributed completely independently from mainland methamphetamine networks so for several years users (and some law enforcement officials) assumed ice was an entirely different drug from methamphetamine. Although P2P methamphetamine powder was available in Honolulu area beginning as early as the 1960's, its use was generally limited to transplanted haoles (caucasians) from the mainland, and included a small enclave of bikers on the Big Island. In the islands the main stimulant of choice into the 1980's was cocaine.

Thus with no previous history with other forms of methamphetamine, Honolulu users separate ice from methamphetamine products from the mainland. When we began our study many respondents were confused about the link between methamphetamine powder and ice. Most knew nothing about methamphetamine, and those that had heard of it thought that meth was a completely different drug from ice. Now some users think methamphetamine is a type of ice, rather than believing that ice is a type of methamphetamine. It is referred to as "powdered ice" or meth ice.

There are thought to be several influences on the tremendous growth of ice in Honolulu after 1987. Residents were both pushed away from pakololo, their staple drug of choice, and pulled toward ice by a well organized marketing campaign by Asian distributors. Also, the overwhelming smokeable drug of choice, marijuana or pakalolo, which has been grown and used throughout the islands for many years, became the target of a government eradication campaign. This drove up prices, drastically reduced availability and left locals without their customary, and many would say relatively benign, smoke. Also very importantly, many locals derived either part or all of their livelihood from marijuana production, robbed of this needed income many experienced considerable economic hardship. Thus when a new, easy to use, smokeable product entered the drug market, one which at first felt non-threatening to youthful novitiates -- ice it was readily accepted as a product to be used and sold. Initial users were often likely to think of it as a substitute of sorts for pakololo (Dayton, 1994).

1. Description of Ice.

Ephedrine is also the precursor for the "Ice" type of methamphetamine. In fact, the Federal Register defines ice as a "mixture or substance containing d-methamphetamine HCl of at least 80 percent purity (Federal Register 1991). Ice appears in a translucent, crystalline form, usually smoked in a glass pipe. The name "ice" refers to the appearance of the product. One user when asked to describe it, stated:

Looks kinda like rock salt, clear. Almost like rock candy. Some can be big, like a diamond, looks almost like diamonds! (488)

There are two other names used as well. The most common is "batu" an Ilocano word from the Philippines meaning "rock" which is widely used among several ethnic populations of ice users in Hawaii. Also known in Hawaii, but less commonly used, is "Shabu" which is Japanese. It is interesting to note that in the Philippines, ice is more commonly referred to by its Japanese rather than by its Ilocano name.

2. Patterns of Availability and Price

The earliest reports of ice in Honolulu date back to the late 1970s, although use did not begin to rise until the mid-eighties. By 1989 use had exploded into "epidemic" proportions, and the news of a drug potentially more dangerous than crack was headline news across the country (cf. Essoyan, 1989; Holmes, 1989; Lemer, 1989; Zurer, 1989; Corwin, 1989; Holmes, 1989; Tabor 1989). Ice arrests were three times higher in 1989 than in 1987 (Crime in Hawaii, 1990) As one user states, by 1990 there was widespread availability:

When I went in jail in 1987, it didn't seem it was that rampant. But when I came out at the beginning of 1990, it was everywhere! It was like an epidemic! Everywhere you turned, everybody was smoking it! Before I went in, I knew a few dealers and most people I knew didn't use it. The locals, they didn't even know where to get it! If you didn't have any connections, you could ask anybody who was into drugs and they'd know where to get it for you." (519)

By 1991, however, the use of ice had begun to drop according to a number of indicators. Although the exact source of the drought could not be established, there was no doubt that ice had "dried up," and that the price had soared. According to the Honolulu police:

An ounce of crystal meth now costs nearly $21,000 on the street --nearly double the price of a year ago. The street price of ice tripled in the first half or so of 1990 (Honolulu Advertiser, 1991)

Ice is generally packaged in "papers" which sell for $25, $50 or $100. The relationship between volume and price vary widely. Because it is purchased by the "paper" and not by weight, there is tremendous uncertainty on the cost per gram. At times a $50 paper buys one-eighth of a gram and a $100 paper a quarter gram. More often, however, a paper buys only one-tenth of a gram. Many respondents believe that in 1989 a $25 paper bought a fourth of a gram. When the 1991 drought brought the price up, the lack of experience buying in grams resulted in widely differing accounts concerning price. This is seen in the following examples.A local woman who began smoking ice in 1985 states:

When I first started to smoke, it was really cheap! $25 to $50 for 1/4 gram! At one point, it went up to, we hit the drought, you could hardly get any ICE at all! Very seldom you're gonna find and it's even gonna go up to $200 for 1/4 gram! That's the most it went up to. That was a few years ago.(1989) ... it was mean! An eight was like $2000! For 1/4 gram it was about $250! (459)

Another user complained.

> *Out on the street, it's really expensive. It varies from week to week, even month to month, it depends on how much is around. ...1986 one gram sold for $450. In 1987, that same gram sold for $600. Now, one gram currently goes for $200 to $250 per gram. (519)*

By mid 1992, there was another major fluxuation. There was more availability and the price had declined. However, as one respondent stated the continued fluxuations were based on other reasons:

> *One gram is anywhere from $375 to $450, depends on who you're talking to or what you do for a living, too. Or who you know (530).*

3. Source of Ice

According to our respondents, as well as government data, ice is primarily produced in, and distributed from, the Far East, especially the Philippines, Korea, Taiwan, and Japan (Adamski, 1992; Glauberman, 1992). There is also evidence that mainland China is involved as the source of ephedrine. More recent, but less well documented evidence suggest the existence of distribution networks involving the Mainland, Canada and Mexico. Basically, however, ice distribution in Hawaii was an economic enterprise developed by organized crime networks in Japan and Korea with large corporate investors (Adamski,1992; Soto, 1991, Schoenberger, 1992). Manufacturing began in the Far East which had a free flow of ephedrine. Comments from knowledgeable Honolulu respondents indicate that Korean manufacturers may have been the first to begin large-scale production in the mid 1,980s, then transferred their base to either Taiwan or the Phillipines after heavy pressure from Korean law enforcement Glauberman (1992). Before that time, however, some of our respondents claim that ice was distributed, and possibly manufactured in the Philippines. According to most accounts there seems to be a particular link between the Koreans and the Filipinos. One Honolulu respondent offered this assessment.

> *Most people think it's the Filipinos, [in control] but the Koreans give 'em to the Filipinos cause the Filipinos don't talk too much! ... the Filipinos keep their mouth shut! The Koreans don't get into the labor part, they won't take the risks, they just play the big man and distribute. The Filipinos do the dirty work. The stuff comes from Korea, so the only way they can get it is from Koreans. ... I used to think it was coming from the Philippines. But that was dirty stuff, Shabu stuff. It ain't happening (521).*

G. Some Facets Concerning Manufacturing Methamphetamine

In our initial interviews we were given the impression that cooking methamphetamine was easy (as is often repeated in the media and some of the literature), but as our discovery went deeper, we realized that the first group of erstwhile cooks had incomplete knowledge; they knew disparate parts of the process, but not the whole - they were in fact helpers and gofers, not cooks.

We found that most cooks have a long or intense apprenticeship with experienced cooks, going through the process of procuring equipment, setting up a lab. with ventilation and other systems, getting all the chemicals needed, often synthesizing chemicals, learning which chemicals could be substituted (and how that would affect the timing and reaction processes) and importantly, how to

avoid or minimize the dangers of toxic poisoning and explosions, from the beginning to the finished product. (Converting already made methamphetamine oil into powder is comparatively easy - this is the process that several respondents thought was "making methamphetamine.") One or two exceptionally bright and creative respondents learned part of the process "in the field," and then were able to go to a library (when this information was still available) to help them fill in details and refine their product, but despite macho representations that its "easy" to make methamphetamine, the process is moderately complex. Even experienced and capable chemists have problems sometimes, as they deal with explosive and toxic chemical reactions.

When compared to synthesizing LSD or other drugs, methamphetamine may be simpler, but handling the ephedrine reduction process, using hydriodic acid and red phosphorous correctly, apparently takes 72 hours with almost nonstop attention to do correctly. The phenyl-2-propanone and methylamine amalgam is no picnic either. Short cuts and "quicky" methods are frequently said to produce inferior and toxic products, nevertheless there do appear to be a few shorter recipes which, when used in small amounts, produce a tolerable product for the user-cook's own consumption, but even these must be done meticulously to avoid serious problems.

In sum, an experienced chemist, with a complete laboratory and all the pure precursors on hand, could produce methamphetamine with reasonable ease - but it would still require care and monitoring. An illicit cook, with incomplete knowledge, equipment and chemicals, faces a considerable risk of both harming himself, others, and losing a lot of money on batches gone wrong. (Some "cooks" pride themselves on being troubleshooters who would be called upon to redo or fix products which had turned out badly.) A serious "for profit" sized batch requires a 50 to 100 thousand dollar initial investment, so there is a lot at stake when a methamphetamine "cook" is in process.

1. Setting Up: Types of Locations and Physical Plants

Often the manufacturer likes to use a shed, away from any living area, but near enough to connect with electricity. Typically the windows will be covered with heavy black plastic and all apertures will be thoroughly sealed with tape. They use portable fans both for exhausting fumes and some temperature control. The more sophisticated systems have long hoses in the attempt to exhaust the worst fumes hundreds of yards from the cook site.

Another frequently mentioned kitchen site is a motor-home, or large truck, the better versions having generators, air-conditioning, and special filters, but some consist of only an unimproved large van. These have the obvious advantage of mobility; the cook and the group can move to another location after any release of tell-tale fumes, or if they feel that they are drawing any attention or surveillance. The more careless cooks (or those who lack alternatives), may use their own garage, or spare-room, with the usual taped windows and fans, but this is considered risky and often results in either law enforcement busts, or forced abandonment of their (usually rented) home.

Motel Rooms are described as useful for those who use more "quick and dirty" methods. Often only one part of the reaction will be done, and then the cooking group will pack up all the glassware and chemicals and do the next step at another motel, always leaving within one day to stay ahead of exposure. Some of the small quantity cooks may simply use a car with a mini kitchen which will fit into a car trunk, they can cook and move every 8-12 hours. One cook claimed that he would leave a reaction pot in a wooded area and come back a day later when it was done.

... I had different batches going in different stages, I'd take reactions out and set them in a dish somewhere in the trees ... then come back next day...(043)

The ideal set-up was described as a house far from other houses, with its own road, and set deep in trees or desert with adjoining sheds, and far from prying eyes and noses. As described by a community consultant who had moved with these groups in the past:

I hear tell they still raid motel rooms, vans on the street...the detectives from WestNet (S.F. East Bay) ...have big time stuff and small busts going on all the time... little motel rooms. ... The guy just sets up and takes down and splits ... and the MiniWinni's (Winnebagos), every time I look at a big panel truck off the road someplace, I look and go are they or aren't they? ... The foothills are obviously good, in the first place, it's paradise, beautiful area, ... They took me up to the top of a hilltop and show me this old house that they use, the most awesome view ... I thought, this is going to be the center of operations, ... they can afford any land they want. The real thing is the privacy, those windy dirt roads in the hills, past highway 49, its perfect. (cc#4)

2. Setting Up: People/Money/Equipment/Security

One respondent, a woman in her late twenties who started out as a gofer and look-out, and then she began putting together the projects. She always had help with the cooking, never being the main chef.

... there's a few people involved when you're gonna cook. It depends on how much you want to do. What I'm familiar with is that there was 5 or 6 people that got together and put up so much money. Around $50,000 plus lots more dollars to buy the chemicals and glassware. Usually, you're gonna have a security, this guy that I was living with was that, security and an assistant ... He made sure that nobody that isn't supposed to be around comes around, that everybody has some kind of control over the cooking area. ...usually when you have a partnership like that, most of the people have the ability to do whatever is necessary. Cause it's like a little club, a little group, you trust these people and make sure they are loyal and they know what's going on. You have a lot of money invested, being illegal, you don't want any slip ups cause you'll get busted. (255)

A male respondent from the East San Diego County area, who used and cooked for years said he usually cooked in 10 to 40 pound batches. He offered this description of his economic investment:

I've invested as much as $10,000 just in glassware, in chemicals. In the early days, it was pretty cheap. You could make crystal for about $12 an ounce. Now to get freon, you're talking about $500 for a 100lb barrel. In the last few months, I've gone to LA to pick up barrels of freon for somebody. (326)

The process of obtaining the needed chemicals varied considerably over the years depending upon legal restrictions and the type of meth being produced. This African-American cook learned the P2P process in 1963.

... you need phenylacetone or phenyl-2-propanol, and methylamine, and I used ether. Ether was the best reducing agent ... people today us isopropyl alcohol, that's not nearly as good. Later, in the seventies, I had to buy them underground ... I got the phenylacetic acid from out of state. It would cost $5000 for 100 pounds, the rest of the stuff you could still buy ...(043)

Many years later, an experienced cook described his experience with chemical availability:

... it was relatively easy but I had to go out of state to get certain things. Texas was one place to go to get ephedrine. I drove. I'd get anywhere from 50 lbs. minimum on up ... at a standard chemical supply house .. you had to give them a false name, false business, no questions asked. ...This took a lot of time. You'd have to find somebody who had it from another state or somebody would sell you their stash of chemicals. Some people bought 100 lbs. of chemicals so they would run out so quick, they might be a source. Somebody would take a risk to go to Utah and try to get it. It would be divided among whoever put money up front to start with. The chemicals got more and more expensive as the years went by. The Feds watch the chemical supply houses and you have to sign for things with I.D. now. (255)

G. Summary

The long view of methamphetamine production and distribution shows a "text book" example of the difficulty of prohibiting the use of desired chemicals. At each step of the way, attempts at control of methamphetamine availability and use resulted in new, creative and often stronger solutions for its use and manufacture. Evidence from this study suggests that illicit methamphetamine is more widely available than when it was first made in clandestine labs. It is also as strong, often more toxic, and used in larger quantities than the pharmaceutical methamphetamine originally prescribed in the early 1960s.

CHAPTER IV.

STUDY SITE, RESPONDENT AND USE CHARACTERISTICS

A. Introduction

The study was able to reach respondents from diverse cultural backgrounds who represented a wide range of characteristics and user experience. This chapter presents background descriptive data covering site, respondent and use characteristics. The first section of this chapter provides a brief description of each study site. The following section presents data covering the major demographic characteristics of our respondents, followed by descriptions of the major user types.

The remaining sections focus on respondent drug use characteristics. It begins with an overview of alcohol and other drug use history. Next we present findings on the basic characteristics of methamphetamine use among respondents. This includes data on length of time used, level and patterns of use, and primary modes of use. The chapter closes with a summary of findings which reveal unexpectedly strong common background characteristics among respondents across study sites and user types.

B. Study Site Characteristics

1. San Francisco Bay Area

The geographic boundaries in this site were constructed during the pilot phase of the project in developing a systematic sampling strategy aimed at strategic target populations of users in the entire San Francisco Bay Area. Included in this site were the city and county of San Francisco, parts of Marin, Alameda, and Contra Costa counties. (See Appendix C.) This area encompassed target populations from a wide geographical area marking the diversity in demographic characteristics within this site. The majority of our sample were drawn from two major geographical areas: the City of San Francisco, and East Bay communities located in Western portions of Alameda and Contra Costa Counties.

Respondents from the city of San Francisco were drawn from inner city areas such as the Tenderloin, Polk Street, and South of Market. These are neighborhoods comprised of transient hotels, public housing, topless bars, sex shops, punk rock clubs and small commercial enterprises. The varied population in these areas include recently arrived Asian immigrants, low level criminals and hustlers, the mentally ill, alcoholics, substance abusers and assorted homeless living on government assistance, and sex workers of both genders. In addition, there were some respondents from varied city residential neighborhoods, who frequented the more "respectable" dance-clubs and bars.

The Eastern Bay areas were generally rundown and economically declining suburban communities. These include the towns of Richmond Pinole, El Sobrante, San Pablo, along with parts of San Leandro, Hayward, Castro Valley. The city of Richmond has a sizable African American population who came to work in the shipyards during the war and stayed to take on blue-collar jobs in the oil refineries and on the docks. The resident population in the other areas is mostly Anglo, with a sizable Latino minority comprised of blue-collar families who settled the area after World War II to

work in the, now defunct, steel and shipbuilding industry. There are reports of considerable, small-scale, methamphetamine manufacture in both West and East Contra Costa County.

2. San Diego Area

Although this study site included segments of all five major districts in San Diego County, the target sampling design found the highest concentration of users primarily in three of these districts. (See Appendix C) District One is the South Bay which included the coastal communities of Mission Beach, Ocean Beach, Imperial Beach and National City. These are trendy and upper middle class communities mixed with a number of lower-class "beach" sub-cultures who were either homeless or sharing run-down rental units. Along with a small population of the more traditional "surf bums," these included Punk skateboarders; young, long-haired grunge-type stoners. There were also tatoo-covered fearsome looking biker-types, who were more often "pseudo" or wannabe bikers than actual club members. National City and Imperial Beach also included a high proportion of Mexican nationals and Latinos.

The inner city, District Four, included older neighborhoods within the city of San Diego: Normal Heights, downtown, Logan Heights, Sherman Heights, Shell Town and Spring Valley. These comprise residential areas made up of small clapboard houses inhabited largely by minority populations, especially Mexicans and Latinos. The neighborhoods closer to downtown are made up of older rundown hotels and apartments, homeless shelters, and blocks of empty lots and boarded up abandoned buildings. Most of the inhabitants are living below the poverty line, and include homeless, mentally ill, older IV drug users, African American dealers and hustlers, and recent illegal immigrants.

District two is East county made up of communities home to anglo working class, welfare moms and biker user types. The main ethnic group is white with a 10 percent Latino minority. Many parts of East County are considered the heart of methamphetamine use in San Diego County and the domain of criminal methamphetamine manufacturers. According to a community consultant from this area:

> *The district government is El Cajon which is a microcosm of all facets of the meth problem. The surrounding cities of Santee, Lakeside and La Mesa are each somewhat different socio-economic entities but all share a common problem of methamphetamine abuse. The sparsely populated back country provides ample territory for cooking operations, isolationists and otherwise independent folk who have little love for government and cities (cc #4)*

The urban landscape is made up of high density apartment complexes surrounded by auto repair garages, thrift shops, discount stores, along with welfare, homeless and other county service centers (field notes, October, 1991).

3. Honolulu Area

The principal geographic locales selected included the greater metropolitan Honolulu area and suburban communities on both leeward and windward coasts. (See Appendix C.) Approximately 50 percent of the area's total population of almost 800,000 is comprised of Asians and Pacific Islanders: 179,000 Japanese, 92,000 Filipino, 46,000 Chinese, 10,000 Korean, 6,500 Samoans, and 5,500 Hawaiians (State of Hawaii, 1991:41). The major neighborhoods within the city of Honolulu included Kalihi/Palama with a large Filipino population, Palolo which was primarily Samoan and Pacific Islander.

Both of these communities were characterized by large public housing projects, cheap rental units and small houses. Downtown and Waikiki were also major sites, home to more transient and marginal populations. Suburban areas on the south and Leeward coasts included Waipahu and Waianae which are mixed ethnic communities with large numbers Filipino and Native Hawaiian residents. On the windward coast, our study included residents of Kailua and Kanehoe, suburban communities with a large military presence.

C. Demographic Comparisons of Respondents: by Site and Gender

The demographic characteristics of our sample revealed in these findings do not reflect a randomized stratified sampling strategy. Therefore, these results should not be interpreted as a representative sample of methamphetamine users in these sites. Because our design did focus systematically on target populations evidencing high rates of use, these findings provide demographic data on previously unidentified user types. Furthermore, the demographic description of respondents in this study correspond to the data on identified user populations found in treatment and criminal justice indicators in each study site (cf. Newmeyer, 1993; Pennell, 1992; Haight, 1993; Wood and Carlson, 1991).

One primary aim of the study was to locate and examine use among several different user groups according to age, ethnicity and gender. As the findings in Table IV-1 reveal, we found significant differences across study sites in the first two categories. Although the majority of our sample overall were under 40 years of age, significant differences were found across sites. Over half of the Honolulu and San Diego samples were under 30 years of age (56 and 53 percent) compared to less than a third in San Francisco (31 percent). Conversely, over 29 percent of respondents in San Francisco were over 40 years old, compared to less than 7 percent in San Diego, and 15 percent in Honolulu.

Whites accounted for over 55 percent of our sample overall, representing over 79 percent of the San Francisco users, and 74 percent in San Diego. In Honolulu only 12 percent were white, with Asian Pacific Islanders accounting for the vast majority of users at 78 percent. Almost 10 percent of the overall sample were Latino, representing over 17 percent of respondents in San Diego, 6 percent in San Francisco, and 5 percent in Honolulu. The study also included a small subsample of 28 African Americans who represented 10 percent of users interviewed in San Francisco and 4 percent in both San Diego and Honolulu.

Female users comprised almost third of respondents equally across all study sites. This is important in two respects. First, although we did not specifically stratify for gender representation, our target sampling strategy produced a percentage supporting previous estimates in each of our sites. Secondly, considering age and ethnic differences in each area, the similar proportion of females across sites was particularly noteworthy. As seen in Table IV-1, the great majority of women users in Honolulu were Asian/Pacific Islander and significantly younger than those in San Francisco and to a lesser extent than those in San Diego.

The sexual orientation of our respondents varied considerably. Of the 71 homosexual/bisexual users representing approximately 16 percent of the sample, San Francisco accounted for the majority. Almost 31 percent of San Francisco respondents, compared to approximately 8 percent in San Diego and 9 percent in Honolulu identified as either homosexual or bisexual.

In general, users interviewed in this study exhibited very similar socio-economic characteristics by gender and across study sites. They tended to have relatively low levels of education and income. As seen in Table IV-2, however, there were several significant differences reported by respondents in each of these socio-economic indicators. For example, a greater proportion (76 percent) of Honolulu respondents completed 12 years or less of education, compared to 55 percent in San Francisco, and 64 percent in San Diego. This is attributed in part to the relatively younger age of respondents in this site, as well as to the immigrant status of many of our Asian/South Pacific Islander users. It is also interesting to note that a higher percentage of respondents in San Francisco reported having attended or graduated from college: 39 percent, compared to 33 percent in San Diego and only 22 percent in Honolulu. At the same time, however, a significantly larger proportion, 13 percent, of San Francisco respondents completed 8 years or less of school, compared to 6 percent in Honolulu and only 2 percent in San Diego. These overall differences are maintained when controlling for gender.

Differences in education are particularly interesting when income in taken into account. For example, although users in San Francisco tended to have higher education, they also tended to report lower incomes compared to respondents in the other sites with 48 percent reporting incomes of $10,000 or less per year compared to 37 percent in San Diego and 46 percent in Honolulu. Conversely, users in Honolulu were more likely to report annual incomes above $20,000 (34 percent), than San Francisco respondents (22 percent), and those in San Diego (29 percent). This difference is partly explained in Table IV-3 by comparing source of income across study sites. Respondents in San Francisco are less likely to be involved in manual labor, clerical or sales professions than users in San Diego or Honolulu (39 percent compared to 57 and 49 percent respectively). On the other hand, they are more likely to receive their primary source of income from government assistance (19 percent compared to 11 and 13 percent respectively). Also, a higher proportion of San Francisco users reported criminal activities, including drug dealing, as their main income source (33 percent, compared to 25 percent in San Diego and 26 percent in Honolulu).

Compared to males, female respondents accounted for a much higher proportion reporting government assistance as their primary source of income (27 percent compared to 9 percent for males). They were also more likely to be engaged in clerical/sales employment (23 compared to 12 percent), and less likely than males to work as manual laborers (19 compared to 40 percent). It is important to note, however, that although less than men, a significant minority of women reported the primary source of their income from illicit activities (22 percent compared to 31 percent for males).

Our findings on marital status reveal that overall a relatively small proportion of our sample reported being married at the time of interview. However, some significant gender differences were found in each study site. As seen in Table IV-4, a higher proportion of women than men in San Francisco and Honolulu were married at the time of interview (28 compared to 11 percent in San Francisco, and 22 compared to 14 percent in Honolulu). Also, in all sites a higher proportion of men reported having never been married. The largest discrepancy was found in San Francisco with 63 percent of men compared to 35 percent of women had never been married at the time of interview. This is due, in part, to the larger proportion of gay respondents in this study site. In San Diego, however, these differences were also significant with 65 percent of males and 43 percent of females stating they had never been married. In addition, more women in all study sites reported being divorced than men, with the largest difference seen in San Diego where 45 percent of women compared to 24 percent of men fell within this category.

D. Profiles of Major User Types

Our preliminary findings reveal generally fragmented and non-cohesive networks of methamphetamine users, who tend to move in and out of various scenes, neighborhoods, and activities. Across all study sites, respondents were often unemployed, on welfare and/or often involved in "deviant" lifestyles. There are few well-defined methamphetamine user groups. Instead, one sees many different networks of users and sellers in each area who move in and out of the drug scene. Isolation becomes a theme for many, especially as their use becomes more out of control. Stable user groups are emphatically not the norm. Thus. the following section profiles user "types" rather than discreet groups, and it is not unusual for respondents to belong to more than one user type.

1. Marginal Anglo Working Class

This user type represents a large proportion of the study sample in both California sites. In each area they lived in declining economic communities on the on the periphery of coast urban cities. Some of these respondents had jobs, but for most, were intermittent or temporary. Small construction, dry-walling, carpenter, waitress, mechanic, and warehouse jobs were the main employment, or more often ex-employment.

a) Eastern San Francisco Bay Area: These users were raised in blue-collar families in older working class suburban neighborhoods. With the erosion of the industrial economic base in these communities, these respondents tended to be under or unemployed. Compared to respondents in San Francisco they had less education. Over 71 percent of this group had 12 years or less education, compared to 55 percent of the overall sample. However the East Bay sample were more likely to have higher incomes. Over 33 percent report incomes of over $20,000 per year compared to 18 percent of the overall San Francisco sample. They also tended to be younger, with over 86 percent under 40 years of age compared to 40 percent for the San Francisco sample in general.

These user types were most evident in Contra Costa County in the East Bay, and often overlapped with biker user types. They live in small, rented suburban houses or apartments, with yards full of old cars, trailers, and various disassembled objects. As one East Bay user stated:

> *San Pablo boys. If that means anything to you, grubby, but usually people who work...a motorcycle shop or maybe a foundry. A blue collar working class, not professional people... [Bikers] and people I wouldn't want usually to hang around my house are the kind of people I would buy it from, cause they are the kind of people I grew up around... I've known these people all my life. On the same level I deal with these people on different levels, other than dope. These are my friends, these are people I go to the park with their kids... Its very much family and friends, watching TV, there might be 18 people at a party and 7 of those people might do dope and the other 11 do not but they are all family members and think of one another as equals. (081)*

b) Eastern San Diego County: The many respondents from the suburban and rural areas east of San Diego share much in common with their counterparts in the East San Francisco Bay sites. The predominantly white users in these areas have also come to possess a strong "local tradition and language" evolving out of the now endemic status of methamphetamine in their communities. As a knowledgeable "community consultant" described this area and its users:

Historically considered the heart of meth use in San Diego County, the Eastern District has long been the domain of manufacturers, outlaw bike gangs, white supremacists, white trash and criminal meth cartels. The urban areas of East county are dense with rental units, AFDC welfare mothers, dumpster divers and swap meeters. (CC#4)

Generally younger and less experienced than their East Bay counterparts, these San Diego users have led what could be best regarded as a "second wave" of methamphetamine use among white, working class populations at the beginning of the 1980s. Unlike many of their counterparts residing in San Diego or either side of the San Francisco Bay, respondents in these East County communities largely avoided the injecting methamphetamine. Instead, for those who broke from the majority who continued to rely on snorting as their mode of choice, smoking emerged as the predominant and controversial alternative.

2. Outlaw-Bikers

There were approximately 35-40 respondents who reported substantial membership or affiliation with an outlaw biker group during some point in their meth using career. These user types were divided evenly between the San Francisco Bay Area and San Diego sites, and generally found in the Eastern communities in each site. Many participated in biker lifestyles, associated with club members, and had business relations with biker clubs either as runners or cooks but were not "official" club members. The overwhelming majority of these user types, both members and associates, were heavily involved in manufacture, distribution and use. Most had criminal records as well. "Crank" is a drug of choice perfectly suited for the biker lifestyle which emphasizes fast, high-risk motorcycling, fighting, heavy drinking and barbiturate use.

One theme which cropped up in most of our biker interviews was the contradiction between the long-standing edict in most clubs against injection drug use by members (on pain of expulsion and more as this would put the whole club at risk). And the frequency with which it was broken - most members or ex-members had either used IV, or had friends that did (under the counter). The cooks seemed open about it, based perhaps on their elite status within these groups.

On the whole, bikers do not "work" in the usual sense, and among other illicit activities they still play a role in the manufacture and distribution of methamphetamine in certain areas. Despite an overall decrease in the dominance of bikers in methamphetamine distribution since the late 1970's (in California), they still instill fear in working-class neighborhoods in both California research sites, using intimidation strategies such as: car and house fires, physical beatings, and alleged killings. This effectively keeps users in these areas extremely careful with what they say. Drug paranoia engendered by crank use helps the biker fear campaign, users imagine surveillance by the bikers even when it isn't happening.

3. Welfare Moms

A number of female respondents were on welfare, most receiving Aid to Families with Dependent Children (AFDC), and living in subsidized housing in poor suburban areas. They were primarily found in the Eastern areas of San Diego, but many were also represented in our Honolulu sample. Most married and/or had children during their late teens or early adult years. For most of these mothers, methamphetamine provides long lasting energy for managing children and household

chores. Although many of them report prior family abuse, they maintain periodic contact with and reliance on family members (primarily their mothers and siblings), and obtain some level of social support from these resources.

Most women users on welfare are also involved in selling, dealing or distribution of methamphetamine. For many, it provides a needed supplement to their meager incomes, and pays for their continued use. For some, dealing also offers a way to become economically independent while providing a boost to their self-esteem. In some areas, especially eastern San Diego County, these users comprise mutually supportive sub-cultures.

4. Gays and Bisexuals

Over half of the large sample of 71 gay and bisexual users interviewed for this study were found living in inner city neighborhoods of San Francisco. The remainder were evenly divided between the San Diego and Honolulu sites. Although over half of these users were Anglos, the study included a diverse sample of gay/bisexual users from several cultural groups. Over three-fourths (8) of the Honolulu gay/bisexual sample were from Asian/Pacific Island ethnic backgrounds. The study also included eight African American and five Latino gay/bisexual users within various study sites. Overall we found that minority gay respondents tended to take on similar behavior patterns to anglo gays. A major finding from this group is the higher proportion of IV users among gay respondents compared to the overall sample. Injection of methamphetamine was the primary mode of use for 33 percent of the overall sample, but over one half of gay/bisexual respondents were primary injection users. Moreover, all of the lesbian respondents were active IV meth users.

For many active gay or bisexual males methamphetamine use was inextricably entwined with their sexual behavior. The overall impression is that one could not move for long in many gay circles without running into methamphetamine as crystal plays a major role, particularly in sexually active groups, and for many of these respondents it is an important catalyst for their sexuality. Also, this user type also involves a clearly permeable connection for methamphetamine from the "working" or "street" class to the middle-class. This is most easily seen when "9 to 5" successful gays make their jaunts into the city where, at the clubs or cruising the street, they can pick up a partner, whether a sex-worker or not, and have an excellent chance of being able to buy and/or get high on methamphetamine. Some of our gay respondents assert that since the late sixties gay males controlled the distribution and manufacture of some methamphetamine from the Russian River and Clear Lake regions, and hence had their own networks; from chemists to consumers.

5. Long-Time/Outlaw Inner City Users

Most of these user types were found in San Francisco inner city neighborhoods especially the Tenderloin Area. They were also found in the downtown areas in San Diego. In both sites these users tended to have led marginal lifestyles for a long period of time, alternating between jail, public assistance and periods of hustling and dealing drugs. They also tended to be older and to have used for the longest number of years. Most were IV users with heroin use histories. A number were currently on methadone. In both cities they came from fairly diverse ethnic backgrounds comprising African American, Latino and Caucasian, male and female survivors of early meth use eras. Many users have accompanying mental and physical health problems, some of which are fairly serious. For example, two of these respondents have died since they were interviewed for this study. Their common history and survival needs are the main reasons why these users, especially in San Francisco's Tenderloin, come close to comprising a more traditional sub-culture or user group.

6. African American Users

As outlined in the previous chapter, African Americans no longer represent as significant a proportion of methamphetamine users as they did in the early 1960s. However, we were able to sample 28 respondents representing a range of experience and use patterns. Over half, or 16 respondents, were interviewed in San Francisco, with the remainder split evenly between San Diego and Honolulu sites.

Most of the African American respondents were older than the sample in general. Only 4 were under the age of 30, and over two-thirds of this population were over 40 years of age. Importantly, these users had some of the lengthiest histories of speed and methamphetamine use. In San Francisco, for example, the average number of years used for those 30 years or older was 23 years. However, their amount of use averaged under 4 grams per month. The preferred mode of use among African American respondents varied both within and across sites. Only five reported snorting as their primary use mode. The remaining sample were divided evenly between injection and smoking as preferred routes of use.

In all three sites most were living in inner-city areas. Although their level of education averaged slightly higher than the general population of respondents, their level of income was moderately lower. Only three reported current incomes of $20,000 per year or above, while almost two-thirds (60 percent) of this user population gave their income per year to be less than $10,000 per year.

7. Latinos

Latino respondents varied on several levels. Of the 46 respondents identifying as Latino, over two thirds were Mexican or Mexican American, from the San Diego study site. Overwhelmingly male, they lived in South and Inner-city areas where they lived on subsistence levels, generally making their living by petty theft and/or dealing. All but one reported engaging in meth sales, mostly on a lower level. Latino males were much more likely than respondents in general to have been convicted of a felony,(58 percent to 26 percent): Much of this activity was organized around gang organizations, some of which were reported to have connections to meth distribution networks in Mexico. They tended to live in central city, or south west suburbs such as Imperial Beach and Ocean Beach and National Beach which is a major land smuggling area for drug from Mexico. Most of the Latinos interviewed in Honolulu, and San Francisco were Puerto Rican, with the remainder Central or South American.

The mode of use for Latino users tended to follow the general pattern in each site. However, in San Diego more smokers (25 percent) were found among Latinos than among other users in this site. This may be associated with the popularity of smoking meth in "light bulbs" described below.

8. Asian/Pacific Americans: Honolulu

Almost all our Asian Pacific American respondents were from the Honolulu site, and represent the tremendous ethnic diversity within the Asian populations in Hawaii. Of the 150 respondents from this site, three-fourths of them were of Asian Pacific American ethnicity. The main ethnic groups include: Japanese, Chinese, Korean, Filipino, Samoan. However, over one-half identified themselves as having a mixed Asian/Pacific ethnic heritage which often included Portuguese and Puerto Ricans.

These ethnicities represent long-term residents in Honolulu and fit the ethnic proportion in the general population.

The median age for both males and females was 27 years. Slightly more than half of the respondents had children, and mothers were more likely to live with their children than the fathers. Fifty percent of the men and 30 percent of the women had not completed high school. Because Hawaii's major industry is tourism, most accessible jobs are in the hotel, restaurant and retail businesses and construction. Slightly over 40 percent of the men worked as unskilled and skilled laborers. Another 30 percent supported themselves through illegal activities such as drug dealing. Women were more likely to be employed in clerical or retail positions (19 percent), receiving assistance from the government (22 percent) or their family (22 percent).

Honolulu respondents grew up, in varying degrees, in an extended family network, and is associated with the spirit of "ohana." In contemporary Honolulu, where the cost of living is one of the highest in the nation, this extended family arrangement becomes particularly salient. Over 80 percent of the men and women in this study come from working and lower working class family backgrounds. The local extended kinship system offers financially strapped families, like the ones' our respondents came from, a realistic a readily accessible resource to draw upon for short or long term relief.

Also, in Pacific Island societies, families live in open settings where behavior is clearly visible to all, and hence, young people's behavior can be directly controlled and sanctioned. Troublesome youth are sent to live with neighboring relatives. Approximately 18 percent indicated that they lived primarily with their grandparents or aunties and uncles until adulthood. Their life histories, however, indicate that a higher proportion lived between households of their parents and other relatives.

a) Filipinos: Out of the 150 in depth interviews conducted in Honolulu, 31 respondents were from Filipino or Mixed-Filipino ethnic backgrounds. These respondents tended to be slightly younger than other Honolulu respondents (62 percent compared to 56 percent under the age of 30). However, they reported higher amounts of use per month over a longer period of time than all other ethnic groups except Caucasians and Native Hawaiians. Over one-half (16) had spent time in Jail or prison. Almost one-third (10) were involved in distribution and sales of ice as a primary occupation. Filipino women tended to be younger than other women in the study and younger than the Filipino males interviewed. Out of the seven Filipino women interviewed, five were under 25 years of age, and the other two were under 37 years old. However, they also tended to be heavier users and to have used for a longer period of time.

Almost all Filipino respondents reported a history of parental alcoholism, with parents allowing and often encouraging drinking at a very young age. Our analyses also reveal that the interconnection of both drug use and distribution is tied into family networks. A high number respondents, for example, reported acting as dealers or "runners" for an older relative who was selling marijuana or ice. After suffering serious consequences or loss of employment due to their use of drugs, Filipino respondents are more likely to become involved in drug dealing and distribution, and less likely to utilize public assistance (unemployment benefits, welfare) or to seek treatment than other respondents in the Honolulu sample. Finally, we are finding that compared to other respondents in our Honolulu sample, Filipino users, especially males, are more likely to become violent while on ice.

b) Samoans: Of the 150 respondents in the Honolulu site, 13 percent (N=20) were of Samoan ethnicity. The vast majority of the Samoan users interviewed were male (n=17), ranging in age from

18 to 39. The average age of the males was 22.5. The three Samoan women interviewed were significantly younger than their male counterparts with all of them reporting to be 19 years of age.

Our Samoan respondents lived in working and lower working class communities with over 60 percent residing in the rural or "country" areas of the island. In addition, most were working in unskilled jobs and experienced periods of underemployment and unemployment, and as a result, lived at or below the poverty line. Seven of the men sold and dealt ice as their major means of financial support. Three-fourths reported having a criminal history. The average length of time reported for ice us among men was 5 years, compared to only 3 years for Samoan women. Samoan males also use in larger quantities on the average at 6 grams per month, compared to the 2 gram per month average for women.

c) Native Hawaiians: The Asian Pacific American ice users in Honolulu who identified their ethnicity as Hawaiian represent a large proportion of the total sample (n=45 or 30 percent). The majority are of mixed ethnicity but identify most closely with Hawaiian ancestry. The characteristics of this user group differ significantly from our other Asian Pacific Americans. First, while women, in general, represented approximately one-third of users across sites, over 46 percent of the Hawaiians were women. Second, the average age of our male and female respondents was slightly older than other Asian Pacific American groups. The age range of the Hawaiian women was 18 to 42 with an average age of 30.2. Similarly, the age range of the males was 18 to 45, and the mean age was 30.4. They were somewhat similar to Samoans in terms of use patterns. Hawaiian women reported that they had been using for 4.4 years, and men for 4.6 years. Moreover they tended to use in relatively large quantities, averaging 4.6 grams per month.

Hawaiians share a number of characteristics with other user types. Nearly all of the males and females were working and lower working class and went through periods of unemployment and underemployment. Most had held either blue collar and unskilled jobs like truck driving, janitorial services, warehouse stocking or collected welfare. The majority were involved in selling at varying levels ranging from trading to distributing. While the majority of the men had a prior criminal record, fewer number of women had been arrested.

d) Asians: This user group includes those of Chinese, Japanese, Korean, and "hapa" (half Caucasian and half Asian) ethnicity. They represent eight percent of the total Honolulu sample (n=12). Three-fourths of the Asian users were male, with an average age of 28. The mean age for Asian females was 25.8. Asians reported using for a relatively longer period than Samoans and Hawaiians. While Asian women had been using for an average of 5.2 years, their male counterparts had used for an average of 6.4 years. Women used an average of 3.5 grams per month compared to males who used an average of 7.1 grams during a thirty day period. Like the other groups, Asian women and men came from working and lower working class backgrounds, and are employed in service industry and unskilled laboring occupations. Moveover all the men report dealing and have a criminal history record. Two Asian women respondents stated that they were involved in selling, and one had been previously arrested.

e) Asian/Pacific Island Women and Batunas: We have found few female Asian American moderate to heavy methamphetamine users in the mainland sites. Consequently, nearly all of the Asian women in this sample are from Honolulu. The majority of these women are of mixed ethnic heritage (e.g., Hawaiian, Chinese, Japanese, Filipino, German, Puerto Rican, Portuguese), a distinguishing characteristic of many Hawaiian residents.

Asian American female users interviewed vary considerably in age, from 18 to 38 years old. They report, on the average, that illicit drug use began in their early teens with pakalolo; a drug which is culturally accepted, and quite common among females in Honolulu both young and old. Some of these women indicate that a family member or peers first introduced them to "batu" or "ice" while others were first introduced by their male partners. Their continuation of use usually takes place with a male partner. While married women tend to use with their husbands, single women frequently move in and out of relationships that involve methamphetamine use. Asian women tend not to purchase ice themselves. Rather, they rely on males to procure their supply. Many of these women could be called "batunas." They hang out with dealers often doing chores and running errands to procure their ice.

f) Honolulu Inner City Homeless Users: Especially visible are homeless users living in city and beach parks, and on the fringes of Waikiki. They are both "locals" and "local haoles," (and a large number of mainland transplants) who make their living hustling, often off tourists -- selling bogus or inferior marijuana (pakalolo), strings of beads, and other items. Although destitute, they somehow manage to get their methamphetamine by selling, serving as the "middle man" or chipping in together to "make a buy." The local homeless women found in this group tend to make their living by prostitution, generally to make enough money to buy ice for themselves and their boyfriends.

E. Use Characteristics: Lifetime Use of Other Drugs

We found several significant differences across study sites related to the nature and extent of respondent alcohol and illicit drug use experience. The findings on lifetime use of alcohol and other drugs found in Table IV-5 reveal a surprising depth and range of experience with all the major illicit drugs available today. Over 95 percent of the total sample have at least some experience with alcohol, marijuana, and powder cocaine. Over two-thirds are familiar with the use of crack cocaine and psychedelics. Almost half have used heroin, and 60 percent report the use of tranquilizers. Controlling by study site these quantitative data suggest important differences in the character and depth of experience of users in each area. Information from the qualitative depth interviews are able to uncover the texture and meaning behind these drug use characteristics.

1. Alcohol

Findings in Table IV-5 show that the most extensive lifetime use of alcohol is found among respondents in San Diego and Honolulu even though they are considerably younger than the users in inner-city San Francisco. One explanation could be found in the life histories of San Diego and Honolulu users which reveal alcohol use beginning at very young ages.

> *Oh, I got drunk when I was 2 years old, my Dad came home and I was drunk, flopping around on the floor, my Mom and his brother were so drunk bullshitting that they didn't even know that I had been fuckin' taking their drinks. ... [getting older] I did have my head in the toilet a few times. On my 13th birthday they let me get drunk and then they let me drink at home once in a while, one beer or whatever. (296)*

Very similar patterns were found among users in the San Francisco East Bay target areas. A respondent from Contra Costa County was already in serious problems from his alcohol use by age 14. He describes how the problem worsened after he was sent to live in another state:

Booze. Not beer, I'm talking straight up, hard liquor! I was about 14 when I was in Washington. That got to become a problem, I became an alcoholic. At a young age. I stole a couple cars up there one night and didn't remember what happened. ...Three of us would get a gallon of hard liquor, Vodka, 10-High and drink until we puked our guts out! Wake up still spinning! Did that every weekend. I went to school, but drank heavily on the weekends. (104)

2. Marijuana

A higher percentage of respondents in all three sites reported more extensive lifetime use of marijuana than alcohol. Table IV-5 shows that three-fourths of users report having smoked marijuana over 1000 times, compared to two-thirds at the same use level for alcohol. Given the assumption that marijuana is considered a primary drug of choice in Hawaii, it is surprising to find in Table IV-5 that a higher proportion of respondents in California than in Honolulu reported lifetime use events of 2000 or more, which is at least six years of daily use. This appears to be a function of the younger respondents in Honolulu. In our qualitative interviews, however, respondents talk about the effects of the legal suppression of marijuana in Hawaii which began about five years ago. Although both states had big eradication efforts, the impact would be more pronounced in Hawaii given the smaller size of the community, and a greater lack of resources to draw on locally to buy this drug. Thus, many of our users report being forced to cut back or even to quit their marijuana use even before ice became readily available.

3. Cocaine

Cocaine was a standard drug in the illicit pharmacopeia of our respondents. Table IV-5 shows that over two thirds report using the powdered form at least 100 times. The table also shows higher-than-expected lifetime use by Honolulu respondents. Since there is so little injection drug use of any drug, the assumption would be that these respondents are for the most part snorting the drug.

With Crack Cocaine, Table IV-5 reveals several significant differences across study sites. There was a significantly higher percentage of users in San Diego reporting they had never used crack cocaine. In San Francisco and Honolulu one-fourth reported never using crack, compared to over 43 percent in San Diego. Another significant difference is found between Honolulu users and Mainland users of crack cocaine as well. Over 46 percent of Honolulu users report using crack over 100 times compared to 14 percent in San Diego and 18 percent in San Francisco. Interview statements from users in Honolulu reveal that crack has been used as a substitute for ice during the periods in the early 1990s when availability declined and the price increased by 300 percent or more. Also as we discuss in Chapter VI, many respondents in Honolulu described smoking crack before switching to ice.

4. Heroin

The difference between the proportion of San Francisco respondents reporting any lifetime heroin use compared to San Diego and Honolulu is statistically significant: 70 percent, compared to 39 percent in San Diego and 27 percent in Honolulu. This is most likely due to the history and institutionalization of this drug in the Bay Area, and the age and experience of respondents in this site. For example, 20 percent of respondents in San Francisco report using heroin over 1000 times, compared to 8 percent in San Diego and 7 percent in Honolulu.

5. Psychedelics and Tranquilizers:

There are significant differences between Honolulu and California respondents on their experience with both of these drugs. In Honolulu over 40 percent had never used psychedelics compared to less than 15 percent in both California sites. In addition over one-half of Honolulu respondents never used tranquilizers, compared to approximately one-third in California.

6. Poly-Drug Use Histories

Examination of the drug use histories of our respondents reveal several distinct categories of lifetime use. One type of background is the poly-drug, poly-modal, insatiable consumer. Once they begin to use, the flood gates are open. This 29 year old native Hawaiian/Filipino born and raised on the islands and is currently homeless. His use history reads like a consumer catalog.

> *He began smoking pacalolo at age 12 in the sixth grade, and within two weeks was a daily user. A few months later, some friends offered him alcohol which he began drinking until he got drunk. In the 7th grade he added Quaaludes and Valium. He said the Quaaludes relaxed him unless he ate too much and became violent. The next drug was powder cocaine which his friends gave him to wake him up from all the pills he took. For a month or so soon after, he experimented with shooting heroin and coke. After than he smoked heroin with foil. He came somewhat late to ice use--only five years ago--considering his 17 year history. (Summary:543)*

Another type of poly-drug, poly-modal user is found among respondents with disruptive family circumstances, where first use is often described as a response to family-related stress. An example is a respondent from San Diego, who first smoked pot when he was eleven years old.

> *First was marijuana from my brother. He didn't smoke it with me but he smoked in the house and I saw him. I smoked it first with a friend of my mother's son. ...everything seemed a lot funnier, a lot lighter. I smoked when my parents split up and that took me away from reality a bit. (266)*

By eighth grade, he had begun more active use, but still managed to maintain a productive life at school.

> *I was in a band, I was exposed to any drug I wanted then. I experimented with mushrooms, marijuana, crystal, alcohol, ...did quite a bit of partying, actually. I used to get high before school, smoking pot, go in and do my work. Go home and do my homework, I stayed on the Honor Roll. I concentrated on what I had to do and did it. I think marijuana made it easier. (266)*

F. Meth Use Characteristics: Length of Meth Use Careers

A major finding emerging from this community study was the lengthy careers of methamphetamine use found in our sample. As seen in Table IV-6 our mainland sample was largely composed of longtime users deeply immersed in various social networks or worlds of meth use. Importantly, these findings reveal a clear correlation between the average age of respondents in each

site, the historical chronology of meth use in each area, and the average length of use for respondents in different study locales. In San Francisco where over 30 percent of respondents were over 40 years of age, for example, they also tended to have used for a longer period of time, with 42 percent reporting 10 to 15 years of meth use experience. Importantly, 30 percent of the San Francisco sample had used for 20 years or more, including 42 users who began using back in the 1950s and early 1960s.

In the Honolulu area, on the other hand, methamphetamine is a relatively recent phenomenon marked by the emergence of "Ice" during the 1980s. Over half of this population is under 30 years of age (56 percent), and the overwhelming majority began using meth after 1984 (86 percent). The user population in San Diego falls in between both in terms of age and experience. Although 53 percent were under the age of 30, less than 7 percent were over 40 years of age. Over three fourths of these respondents began using speed or meth between 1976 and 1987. This corresponds to the growing distribution and manufacturing networks which began to develop in this area during this period.

G. Meth Use Characteristics: Routes of Administration

Modes of use reported by respondents at the time of interview differed significantly by study site. As seen in Table IV-7 injectors account for 67 percent of the San Francisco sample, snorters for 70 percent of respondents in San Diego, while 92 percent of the Honolulu users are primarily smokers.

1. Oral

Longtime users in our sample often began their "speed careers" with any of the popular pharmaceutical stimulants which remained widely available up until the early 1970s. At least initially, these respondents generally relied on oral ingestion in sampling a diverse array of amphetamine pills and capsules, such as "bennies," "dexies," and "black beauties." Many of the "old-timers" in the San Francisco Bay Area also had the opportunity to try methamphetamine tablets, primarily Desoxyn. These compounds, whether prescribed or diverted, these tablets were extremely reliable in their action and lent themselves to oral use due to the predictable nature and length of their action. A 56-year-old Tenderloin resident whose initial experience with amphetamine was with tablets given to his unit during the Korean War, states for example:

> *The medic dispensed them to those who needed them on the lines. In 1952 when trench warfare was developed and you were part of night patrols. I took half of one and 15 minutes later, I was ready to patrol! I did most of my 15 months on the front lines under the influence of amphetamine! I wasn't bored. (038)*

In contrast to pills, the oral route is often forgotten amidst the other options which seem more appropriate for using methamphetamine in powder form. Increasingly, initiates turn onto meth through inhalation, injection or smoking routes, instead of swallowing the bitter tasting powder. Nevertheless, some users still view the oral route as the only acceptable option in at least the initial stages of use. However, as evidenced by a 23 year old IV user who began by swallowing meth five years before, such perspectives are rarely set in stone.

I didn't want to snort anything up my nose. I was only drinking and smoking pot then, even though I did that very heavily, I never thought I would ever do anything other than that! He told me I could eat it and I thought it can't be that bad! So I ate it. I ... rolled up the bread and swallowed it with the crank inside. Then I drank a cup of coffee with it. That's what he told me to do. Immediately after I got high off that, I started snorting it. (094)

Oral users tend to be those who want longer acting and "smoother" effects, or those who have burned out their nasal tissue from snorting and are reluctant to use other methods. These fairly rare users, who have given up the quick uptake rush, tend to be the somewhat more controlled users. A woman from East San Diego County stated, for example:

I took it orally. It works better that way. It's more mellow that way. It seems to last longer. The thing about snorting is like the act of doing it. You get addicted to the burn." "Plus, you get this, wham, it just comes on! Rather than eating it or drinking it. I would usually pour it in coffee and sip it." "If you snort it, it burns your sinuses and your eyes are watering. Sometimes you felt like you were gonna gag or vomit. I didn't like that, but I knew when I did it, it just made me instantly awake. The desired effect was there. (201)

One explanation for the overall trend away from oral use is the unpredictability of the effects of non-pharmaceutical methamphetamine. Oral use was often initiated by utilitarian and functional motives and many of the street products fluctuate in their effects. This encourages quicker uptake methods so that the user will know how the methamphetamine works, and can quickly take more drug to calibrate the level sought. In addition the use of quick uptake methods reinforces itself because of the pleasure of the rush - which is absent with oral dosing. For those who do swallow one common method is to drop a spoon of crystal into a cup of coffee another is to put it in a small scrap of tissue, roll it up, and swallow it with water or a drink as if it were a pill - these amounts are often measured by cutting lines out as if to snort, in order to measure the amount. Most users who do swallow good quality crystal feel that they get a longer, less jittery, "high," but mention the absence of a palpable rush, which is a major pull toward faster methods of uptake.

2. Intranasal

Probably the most widely used method of initiation into the use of crystal on the Mainland is nasal inhalation of lines. Although some users find the pain ("the burn") when they first snort intolerable (described as being much harsher than cocaine), others anticipate and enjoy the whole process, (burning nose, watering eyes, the "drip," - the chemical and sinus effect in the back of the throat). About the time all these discomforts (or pleasures) are finishing the rush or onset of the high starts. For some respondents, there was no doubt about the benefits of this mode, even after experimenting with other routes. For example:

Immediately after that first time I was snorting it. All the time, every day, every hour! I began to use every day for a long time. Three years every day snorting it. It made me feel beautiful. I tried shooting it and it didn't make me feel like I was incredibly good looking and successful. If I didn't snort it, it wasn't the same high. (094)

Some users are able to snort extraordinary amounts of methamphetamine, large "ropes" the size of a pencil and weighing a quarter of a gram and more (possibly up to a gram) in one hit.

For those who cannot tolerate the toll on their septum, whether immediately or after long-term use, the search for a less painful method is in order. Seldom do users climb back down the speed ladder from faster to slower uptake methods. As time passes, or sophistication increases on the part of the crystal user, it becomes evident that snorting is not the most efficient or cost effective method for getting high, which induces many users to consider the transition to IV use.

3. IV - Shooting

A few of our respondents began using methamphetamine IV., but most are taught by friends or associates. For most users obtaining the syringe, measuring the water, "hitting" a vein, and correctly "slamming" the dose can be difficult even with experience, for an initiate it is almost impossible. In fact, a few IV users go for years having a partner or friend "fix" them. Even when combining those difficulties with the stigma against needle use, and the fear of disease transmission, this method is far from declining. Other factors seem to overcome the negatives. Some respondents were very clear about their preference for this route from the very beginning.

If any one in their circle is "slamming," they have an easy entre into shooting. Even if no one they know is shooting, it usually doesn't take long to find someone who is. With regularity our respondents who try the IV method report that they like it so much they scorn other ways of using. As one user stated:

> *Once I put that needle in my arm I changed forever! That's what I wanted to do above anything else. (052)*

Another respondent relived the feeling in his interview:

> *It's like the action of being able to draw it up in the spoon, the ritual of using the needle and feeling as it went in, each, even as it went in, I can't finish! Yeah, that's it. Don't forget to rinse it, somebody else gotta use it! Then go off! I'm getting a little bit ecstatic here! (010)*

A frequently described first IV use scenario follows (based on a compendium of interviews). Typically the initiator will hit the new user with a moderate dose of a tenth of a gram or less (street quarters are often two tenths, or even less with a quality product). Ten cc's of water will be drawn into the syringe, and then emptied onto the methamphetamine either in a spoon or into the glassine bag. Cooking should not be required; if the crystal does not melt it is considered bad! Also, some respondents assert that good crystal makes the water temporarily much colder. The solution is then drawn back into the syringe - and should show from 15cc to 20cc return (the water plus the liquified methamphetamine - more return is an indicator of higher quality). After flicking the body of the syringe and pushing out air pockets within by pushing the plunger until the first drops exit the point, the "dose" is ready to be injected.

> *You insert, and the blood is in the needle, you go with your heart beat, and about half way of injecting it and as I'm pulling the needle out I feel myself swoop up and I say 'Oh my god, this is really crank and then I feel real good. (020)*

Feeling the initial cough which overwhelms you, it occurs, you don't have a choice, it happens. From that point, you try to catch your breath cause your heart just took off and left the rest of you. Your skin and hair follicles tingle and then your mind. ..For maybe three hours you're on top of everything.(293)

4. Smoking: Ice in Honolulu

One reason for the popularity of smoking ice in Honolulu is tied into the long tradition of smoking pakololo. The main reason, however, for the growth of ice smoking can be traced to the massive promotion of this import from Asia where smoking a drug was traditionally more common than intranasal or IV use. The process of smoking involves a specially made pipe which is able to save the maximum amount of residue in order to stretch out the substance for a prolonged period of time. One respondent offered a good description:

First you...get a straw and scissors. Cut the straw at a slanted point and then cut the tip off so you don't poke a hole in the bag. Get a Q-tip and clean your pipe. Take the straw and scoop it in and put it in the pipe. Melt it at first, have a wet cloth ready to cool it down, so it hardens back up. Then hold the flame just under the pipe until it starts smoking. Then you start drawing the smoke in and rock the pipe from side to side. Take the flame off and keep drawing. Put your pinky over the hole on top and cool it down. Take your pinky off and suck out the rest of the smoke. (403)

This process of maximizing the number of doses became increasingly important as the price of ice increased dramatically after 1988. This method of smoking, however, was also reported to enhance the effects of the drug. A Black homeless gay user in downtown Honolulu described:

Put it in the pipe. Roll it over while you burn it. Get the cloud real thick and inhale it. If it's real good, you can get a good ringing in your head! Just like if you were gonna shoot! But a different kind of ring from shooting coke! You can also get a good rush. (535)

After 1990, the increasing popularity and demands for the product has resulted in an uncontrolled free market which includes, often inferior, meth from mainland sources. This has resulted in the additional appearance of powder from the mainland which users also smoke in their ice pipes. Usually, however, the result is less than perfect.

They got powdered kind now, but I don't like that. It's a lot bigger, but it tastes terrible. ...it bubbles and leaves a real black thing in the pipe! [Like crank] the old stuff ... That's mostly what they sell on the windward side, that kind. (488)

5. Smoking: in California

We found that independent of the Hawaiian "Ice" phenomenon that there are a surprising number of mainland users who have come to prefer smoking as their route of administration (one respondent started in 1979). Importantly, we found that over 72 percent of our California respondents report having smoked meth, often as a result of damaged nasal passages or aversion to needles. Some are in groups of smokers, but often the smokers are part of other user groups (snorters, or IV users) but have learned to enjoy smoking more. Some smokers alternate between snorting and

smoking, depending on the type of crystal, or the condition of their nose. A very few have given up shooting for smoking, and most of those were because of collapsed veins rather than a preference for smoking.

Some of these smokers may have started because of the quick system for testing the drug they were buying. That was, and still is for some, the heating of a line of product on aluminum foil using a butane lighter underneath - after the drug goes up in smoke if there is only a small translucent stain left they feel it indicates a pure, uncut product, whereas black or brown residues, or lumpy ashes tend to indicate a poor and/or cut drug. At some point one suspects a polydrug user decided to try pulling up the smoke with a straw as in "chasing the dragon." Several respondents, however, eventually learned about the advantage in using a glass pipe, especially the ability to stretch out the amount used per hit. One long time user who has smoked meth in a glass pipe with no negative effects stated:

> *My dealer told me about glass pipes. He showed me how to put some in, melt it and hit it. It was smoother, you didn't have that weird taste in your mouth like with foil. When you snort it was a burn ... you'd sweat when you got the rush. When you smoke it, it hits you softly, cool, you can relax on it, its a less intense kind of wire. ...I take about three hits and there is still lots left. I put the pipe down and go for 4 or 5 hours, if I feel like I'm coming down I hit it again. It lasts a lot longer that way. (088)*

Another respondent offered a similar assessment:

> *If I was snorting it would be all gone. The high is better, it's a little delayed, but it is basically the same, it gives me the energy, It woke me up and want to do something constructive, physical, it would keep me up for days ... if I keep smoking. One time their was no foil so I tried a glass pipe, like freebase, and the results were better. You just drop it in the pipe and heat the pipe up a draw the smoke up. Now I smoke methamphetamine above all other ways. (089)*

6. The Light Bulb Phenomenon

The use of a light bulb for smoking meth is particularly popular in San Diego. This method may be unique to this area, but is well known and widespread among both Hispanic and Caucasian users. An outreach worker for a county program drew from her lengthy experience to explain that, *"The light bulb is just the easiest way to smoke it, just like a beaker, anything glass is perfect to use."* She provided a rationale for its popularity among both Anglos and Latinos with this historical account:

> *...when I was growing up I remember the bikers had it a lot and it was real popular then and among latinos it was coke that was really popular. And then the crank was once in a while used and then the meth came out and then it started getting real popular. This was about 10 years ago. The light bulb is just the easiest way to smoke it, just like a beaker, anything glass is perfect to use. (focus group interview, SD, 1993)*

One woman explained the procedures used in this form of smoking:

You break the top, the part that screws into the socket; you like tap it through the middle and then work it off, work off that thing and rinse it out and get a pair of pliers and hook it like that and you just drop like about a half a quarter in there and you get a straw and you put it on the thing and it's right in the light bulb hole, and you...heat it up and it turns, whoosh, gets all smoke and ...comes out the straw and it's...total rush. (234)

...it's just like as if you were using a dirty needle. OK, this would be like that, if you smoked the numbers [on the bottom of the bulb] or the white part. Everything has to be clean. They really go through a lot just to smoke this stuff. Some people don't have that, they just use the foil and the foil is real popular. ... But the crystal or the ice doesn't last that long, it will burn up quickly, so the best way to use it is the light bulb. I don't know when it came around or how long its been here.. It's just very popular. You do get hooked on the smoke in the mouth, the taste and how I tasted it that's what I thought would give me the rush or get me high, so it doesn't have to do with how good it is, it's that taste, that taste will qualify it. (focus group interview, SD, 1993)

These respondents claim that by smoking meth using a light bulb they were able to improve the quality of the high, have more control over its effects, while having the same amount last longer than when snorting. One user describes this process:

I saw some guys on the job sight with a little light bulb, ...they broke the top off and they had a straw in there and the light pops up and they are sucking on this thing, and I thought "What the hell is that"? I'm curious, ... I have to try this". ... The high was more controllable, I could accomplish things, I could regulate it, ... I could take a line that most people did, I could put it in a light bulb, I could get high off it in the morning, go to work, come home, get high off of it again, maybe get high off it and go out. So that line would last me you know three highs. (296)

G. Meth Use Characteristics: Levels of Use

As can be seen in Table IV-8, most of our respondents in each study site were moderate to heavy users. In San Francisco, the average grams used per month were 6.6; in San Diego the average per month was 7.5 grams and in Honolulu it was the highest averaging 9.6 grams per month.

Our findings show wide variation in each site according to respondent mode of use. In San Francisco, for instance, this was highest among smokers (7.6) followed by injectors (6.6), with snorter averaging the lowest at 2.7 grams per month. In San Diego, however, where snorting was the most popular mode of use, the level of use was higher among smokers at 5.4 grams per month. Both injectors and smokers in San Diego had significantly higher levels of use at 11.3 and 11 grams per month respectively. The level of use among injectors in Honolulu was the highest at 13.9 grams per month, while smokers averaged 9.1 grams per month. Table IV-8 also shows that there were no snorters or oral users in Honolulu, which may account for the higher average use. In addition, there were five users in Honolulu who reported using over 70 grams per month, which also contributes to the high average.

H. Summary

The findings from this study on user characteristics illustrate the commonalities and diversity found among respondents. These users have similar socio-economic backgrounds along with long and experienced histories of illicit drug use. We also found very little gender difference across these basic user characteristics. However, these respondents also represent different cultures and ethnicities. As we demonstrate in the next chapter, these relationships carry over into their experience with methamphetamine.

TABLE IV-1

DEMOGRAPHIC CHARACTERISTICS BY SITE: AGE, GENDER, ETHNICITY (in percents)*

CATEGORY	SAN FRANCISCO (N=150)	SAN DIEGO (N=150)	HONOLULU (N=150)	TOTAL (N=450)
AGE				
18 - 29	31%	53%	56%	47%
30 - 39	40%	41%	29%	36%
40 - 49	21%	5%	15%	14%
50+	8%	1%	0	3%
SEX				
MALE	70%	68%	68%	69%
FEMALE	30%	32%	32%	31%
SEXUAL ORIENTATION				
HETEROSEXUAL	69%	92%	91%	83%
HOMOSEXUAL	19%	6%	6%	10%
BI-SEXUAL	12%	2%	3%	6%
RACE/ETHNICITY				
CAUCASIAN	79%	74%	12%	55%
AFRICAN AMER	10%	5%	5%	7%
LATINO	6%	17%	5%	10%
NATIVE AMER	0%	3%	1%	1%
ASIAN/PAC/ISL	5%	1%	78%	28%

* PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING.

TABLE IV-2

SOCIO-ECONOMIC CHARACTERISTICS: BY SITE

(in percents)*

CATEGORY	SAN FRANCISCO (N=150)	SAN DIEGO (N=150)	HONOLULU (N=150)	SAMPLE AVG % (N=450)
EDUCATION				
1 - 8 YEARS	13%	2%	6%	7%
9 - 12 YEARS	42%	62%	70%	58%
13 - 16 YEARS	39%	33%	22%	31%
17 + YEARS	7%	3%	2%	4%
INCOME				
< 5K	21%	21%	20%	21%
5K - 10	27%	16%	26%	23%
11K - 20K	29%	35%	21%	28%
21K - 30K	11%	14%	15%	13%
31K - 50K	9%	10%	12%	10%
51K +	2%	5%	7%	5%

* PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING

TABLE IV-3

PRIMARY SOURCE OF INCOME: BY SITE AND GENDER
(in numbers and percents)*

OCCUPATION	SAN FRANCISCO (N=150)	SAN DIEGO (N=150)	HONOLULU (N=149)	MALE (N=309)	FEMALE (N=139)
	N (%)	N (%)	N (%)	N (%)	N (%)
EXEC/PROF	8 (5%)	6 (4%)	3 (2%)	12 (4%)	5 (4%)
CLERIC/SALES	23 (15)	25 (17)	20 (13)	36 (12)	32 (23)
MAN LABOR	36 (24)	61 (41)	53 (36)	124 (40)	26 (19)
GVT.ASSTANCE	29 (19)	16 (11)	20 (13)	28 (9)	37 (27)
DRUG DLR/MAN	35 (23)	30 (20)	22 (15)	64 (21)	23 (17)
OTHER CRIME	15 (10)	8 (05)	16 (11)	31 (10)	7 (05)
OTHER LICIT	4 (03)	4 (03)	15 (10)	14 (05)	9 (07)

* PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING

TABLE IV-4

MARITAL STATUS AT TIME OF INTERVIEW: BY SITE AND GENDER
(in percents)*

	SAN FRANCISCO		SAN DIEGO		HONOLULU	
	M (N=103)	F (N=46)	M (N=101)	F (N=49)	M (N=104)	F (N=46)
ARRIED	11%	29%	12%	12%	14%	22%
VORCED/ PARATED/ DOWED	26%	37%	24%+	45%+	24%	26%
EVER ARRIED	63%+	35%+	65%	43%	63%	52%

* Significant at the .05 level

: PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING.

TABLE IV-5

LIFETIME USE OF ALCOHOL AND OTHER DRUGS
(by number and in percents)*

	SAN FRANCISCO N	(%)	SAN DIEGO N	(%)	HONOLULU N	(%)	TOTAL N	(%)
ALCOHOL								
never used	7	(5)%	1	(7)%	7	(05)%	15	(03)%
used at least once	22	(15)	12	(8)	12	(8)	46	(10)
used over 100 x	32	(21)	33	(22)	30	(20)	95	(21)
used over 1000 x	17	(11)	13	(09)	17	(11)	47	(10)
used over 2000 x	72	(48)	91	(61)	84	(56)	247	(55)
MARIJUANA								
never used	3	(2)%	1	(1)%	2	(1)%	6	(1)%
used at least once	17	(11)	10	(7)	12	(8)	39	(9)
used over 100 x	22	(15)	20	(13)	29	(19)	71	(16)
used over 1000 x	14	(9)	8	(5)	19	(13)	41	(9)
used over 2000 x	94	(63)	111	(74)	88	(59)	293	(65)
POWDER COCAINE								
never used	7	(5)%	5	(3)%	12	(8)%	24	(5)%
used at least once	64	(43)	62	(41)	45	(31)	171	(38)
used over 100 x	47	(32)	45	(30)	48	(33)	140	(32)
used over 1000 x	13	(9)	18	(12)	16	(11)	47	(11)
used over 2000 x	18	(12)	20	(13)	25	(17)	63	(14)
CRACK COCAINE								
never used	41	(27)%	64	(43)%	35	(24)%	140	(31)%
at least once	81	(54)	65	(44)	45	(31)	191	(43)
more than 100 x	20	(13)	13	(9)	40	(27)	73	(16)
more than 1000 x	2	(1)	3	(2)	13	(9)	18	(4)
more than 2000 x	6	(4)	4	(3)	14	(10)	24	(5)
HEROIN								
never used	45	(30)%	91	(61)%	104	(73)%	240	(54)%
used at least once	56	(38)	36	(24)	24	(17)	116	(26)
used over 100 x	19	(13)	11	(07)	4	(03)	34	(08)
used over 1000 x	7	(05)	0	(00)	2	(01)	9	(02)
used over 2000 x	22	(15)	12	(08)	8	(06)	42	(10)
PSYCHEDELICS								
never used	18	(12)%	21	(14)%	58	(40)%	97	(22)%
used at least once	73	(49)	94	(63)	50	(34)	217	(49)
more than 100 x	37	(25)	25	(17)	27	(19)	89	(20)
more than 1000 x	6	(04)	3	(02)	5	(03)	14	(03)
more than 2000 x	16	(11)	6	(04)	6	(04)	28	(06)
TRAMQUILIZERS								
never used	46	(31)%	51	(34)%	81	(56)%	178	(40)%
used at least once	54	(36)	62	(42)	33	(23)	149	(34)
used over 100 x	30	(20)	28	(19)	18	(12)	76	(17)
used over 1000 x	7	(05)	3	(02)	7	(05)	17	(04)
used over 2000 x	13	(09)	5	(03)	7	(05)	25	(06)

*PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING

TABLE IV-6

YEAR FIRST USED METH: BY SITE
(by numbers and in percents)*

	SAN FRANCISCO N=149		SAN DIEGO N=150		HONOLULU N=150		TOTAL N=450	
YEAR	N	(%)	N	(%)	N	(%)	N	(%)
1952-1975	44	(30)%+	12	(08)%	1	(.0)%	57	(13)%
1976-1983	62	(42)	71	(47)	20	(13)+	153	(34)
1984-1987	19	(13)+	45	(30)	61	(41)	126	(28)
1988-1992	24	(16)	22	(15)	68	(45)+	114	(25)

+ significant at the .05 level

* PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING

TABLE IV-7

MOST FREQUENTLY USED MODE OF USE: BY SITE
(in percents)*

MODE	SAN FRANCISCO (N=145)		SAN DIEGO (N=148)		HONOLULU (N=137)		TOTAL (N=430)	
	N	(%)	N	(%)	N	(%)	N	(%)
Snort	36	(25)%	103	(70)%+	1	(.7)%	140	(33)%
Inject	97	(67)+	30	(20)	10	(07)	137	(32)
Smoke	12	(08)	15	(10)	126	(92)+	153	(36)

+ significant at the .05 level

*PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING

TABLE IV-8

AVERAGE GRAMS USED PER MONTH: BY SITE AND PRIMARY MODE OF USE
(by number)

SAN FRANCISCO

	NUMBER	AVERAGE	0-2gr	2.25-10gr	11-20gr	21+gr
SNORTERS	28	2.7g	20	7	1	0
INJECTORS	99	6.6g	32	53	8	6
SMOKERS	17	7.6g	6	8	1	2
ORAL	4	6.6g	2	1	1	0
TOTAL	148	6.6g	60	69	11	8

SAN DIEGO

	NUMBER	AVERAGE	0-2gr	2.25-10gr	11-20gr	21+gr
SNORTERS	91	5.4g	44	29	13	5
INJECTORS	34	11.3g	5	16	10	3
SMOKERS	20	11.0g	3	11	3	3
ORAL	2	4.7g	0	2	0	0
TOTAL	147	7.5g	52	58	26	11

HONOLULU

	NUMBER	AVERAGE	0-2gr	2.25-10gr	11-20gr	21+gr
INJECTORS	11	13.9g	2	5	3	1
SMOKERS	129	9.1g	34	70	16	9
TOTAL	140	9.5g	36	75	19	10

CHAPTER V

DISCOVERING METHAMPHETAMINE: ANTECEDENTS, ARENAS AND APPRECIATION OF INITIAL USE

A. Introduction

This chapter provides an in-depth look at the multifaceted meaning and profound role which methamphetamine has come to play in the lives of our respondents. Through the use of quotes from the thousands of pages of interview transcripts, these 450 users convey the complexity and rich diversity of their "meth careers." Approached chronologically, the chapter first explores the historical and individual contextual antecedents which led to initial experimentation among our sample. Cognizant of these rationales, respondents describe the differing motives and reactions surrounding their "discovery" of a substance which, for most, would profoundly impact their lives.

The chapter next illustrates the pivotal role played by various contextual factors which combined to make meth an attractive, available and acceptable commodity. The following sections examine the most commonly mentioned motivations and overall impressions surrounding initial experimentation. In so doing, we will gain some insight into the evolving use patterns and problems examined in subsequent chapters.

B. Legacy of Medical Promotion and Pharmaceutical Overproduction

The social and environmental contexts of initial methamphetamine use among our respondents are a direct result of the historical impact of methamphetamine use in our study sites, especially in California.

1. Overproduction

Overproduction in the pharmaceutical era assured high rates of availability and acceptance of amphetamine compounds for a wide array of utilitarian/functional purposes among even mainstream society. In contrast to other drugs of abuse, many older respondents were initially attracted to amphetamine compounds by the promotion of their therapeutic and utilitarian qualities. These veteran users described how their initial interest and/or experience came through easy prescription or diversion of various pharmaceutical amphetamine compounds. The veteran user who was turned onto Dexedrine by the military in Korea, returned to the states in 1953 and eventually resumed use after a two year hiatus:

> *There was a lot of brightly colored pills on the market at the time! It was really enjoyable for me. I had to try one of each! We had long talks and solved the problems of the world! (038)*

2. Medical Promotion: Appetite Suppression

For some respondents in this study (primarily older females), initial use of amphetamine and related stimulants came through diet prescriptions. Many others sampled some of the ample quantities diverted through nonmedical channels up through the end of the 1960s. However, only a

relatively small number of older respondents were actually prescribed methamphetamine, and most of these were given it in a combination form, typically with barbiturates (e.g., Desbutal and Dexamyl) to counteract the stimulant effects. Most prescriptions were written for other amphetamine or related sympathomimetic compounds (such as phenmetrazine or preludin). This helps account for the qualitatively different recollections of their earlier oral use of these diet medications compared with subsequent experiences with powder methamphetamine. This is illustrated by a woman who was given Benzedrine by her parents for weight loss.

> *She'd give me one pill in the morning and it made me feel strange..I didn't know who I was, because I didn't have my own emotions, I had somebody else's emotions. I couldn't tell nobody about it cause I was told that I would get taken away from her if someone knew.(292)*

Most were turned on to these for dieting by friends and family as adults. Often unclear as to actual identification of "diet pills"--however, the rapid tightening of controls in the last two decades made it more and more likely that the "black beauties" and other diet pills were probably "lookalikes" containing over-the-counter stimulants.

Whether obtained by prescription, over-the-counter or through the black market, the use of stimulants for dieting is more of a gender-based phenomenon than a geographical or socioeconomic one. Female respondents in all three sites cited methamphetamine's reputation as a potent appetite suppressant. This, according to them, was a strong motivator for initiating use. A large, 19-year-old Samoan woman noted how she had been forced to quit "pakalolo" because of a "munchies"-induced weight gain. She heard about this new drug called "batu":

> *'Batu' makes you lose weight. I was thinking, first thing into my mind, lost weight? Okay!! They said, 'Are you sure? You will get addicted to this.' I said, 'No same thing as pakalolo, right?' They said, 'No, it has a strong addiction.' I told myself I'd take a hit here and there, and so I did. (457)*

3. Medical Promotion: Attention Deficit Disorder/"Hyperactivity"

The explosive increase in diagnoses of childhood hyperactivity was fueled by the promotion of the pharmaceutical amphetamine-compound medicines such as Ritalin used to manage this disorder. Over 10 percent of San Francisco respondents (along with 5-7 percent in our San Diego and Hawaii sites) recalled being medically diagnosed as "hyperactive" as children. For these respondents, this diagnosis often resulted in their introduction to prescription stimulants at a very early age.

In addition, much greater numbers of respondents in each site self-diagnosed themselves as "hyperactive" children who would have probably benefitted from a daily stimulant regimen. Among these were older respondents who came of age before drug treatment for this controversial condition came into vogue. An East Bay African American man in his early 40s recounted how he found meth to be the perfect medicine for his "condition" which had continued into adulthood:

> *Back in those days, nobody knew about hyperactivity! As a kid, I think I was. It keeps me in a mellow level. (088)*

4. Medical Promotion: Asthma

An intriguing and somewhat interrelated finding emerging from this study is the unexpected numbers of respondents reporting health problems with asthma, often from early childhood. Various stimulant compounds were among the various medications making up the armatarium employed in combatting often frightening and potentially deadly asthmatic attacks. In addition to opening up breathing passages, it is interesting to observe that most of the asthmatic respondents noted essentially the same "calming" and "normalizing" effects as their hyperactive counterparts.

> *Maybe I have a very high tolerance to drugs, and the reason being is that as a child I was a very bad asthmatic, so I took a lot of medication, which is like a speed. It opens your lungs up. (292)*

Another respondent had been diagnosed with asthma when he was five years of age and been prescribed medication until trying methamphetamine for the first time:

> *I broke the habit, when I was 24 years old, so this is why I was on every asthma medication you can think of--on a daily basis. So when I do ice, it's like taking my medication. (444)*

A male respondent from Honolulu of mixed Filipino ethnicity described his childhood asthma in the context of a chaotic life with a mother who seemed to be heavily involved in a counter-culture world:

> *Around age 12, they introduced this medication on the market ...and it was a unique inhaler thing that was a powder capsule. I used it for one; year it worked for me. I stopped needing the medication that I had been on all my life for asthma. (468)*

Another respondent who was given medicine for his asthma stated:

> *I was born with asthma. I was very sick, but I'm okay now. I was in the hospital a lot and everything. [Since using meth]...I haven't had an attack in years! Long time! Years! (535)*

C. The Intergenerational Experience: "Meth Communities"

1. Parental Use and Abuse of Alcohol and Illicit Drugs

Parental use and abuse of alcohol and illicit drugs were commonly reported. Table V-1, for example, reveals that almost 52 percent stated that one or both parents had serious problems with alcohol. Slightly over 40 percent of both the males and females indicate that at least one parent, usually the father, had problems with alcohol.

> *My old man was a full blown alcoholic! Everybody else thought he was one of the nicest people you could ever meet but at home, he was a fucking prick! ...We were on the run most of the time. He played death games with Russian Roulette, with 6 kids, he always threatened to hurt us! I can remember as kids being woken up in the middle of the night and running out of the house and jumping over the fence and hiding in people's yards, this sounds bizarre, he would drive around the neighborhoods to find mom and us. He'd go nuts for no reason and start beating the hell out of everybody! ... He was a full blown, prick alcoholic! We grew up in that atmosphere. (031)*

Of special significance is the proportion of respondents reporting the use of illicit drugs by parents. (See Table V-1.) This includes marijuana used by 39 percent, cocaine by 18 percent, heroin by 6 percent, and methamphetamine by 20 percent of respondents' parents. It is especially important to note that of the 88 respondents almost half (35) also reported their parent had serious problems with their use. Respondents also indicated that 20 percent of parents who used marijuana, 15 percent of parents who used cocaine, and 50 percent of the parents using heroin all developed problems associated with use. This history had serious consequences for many of these respondents. Some grew up thinking that illicit drug use was a normal activity. For example, by the eighth grade, this respondent knew that his parents were using cocaine:

> *They thought they was being sneaky, but I noticed them doing drugs a lot. Both of them. I used to see them disappear in the bathroom and then leave for the store. I'd see mirrors with cocaine lines on it, right in the bathroom. I thought it was an average house. (492)*

In Honolulu, respondents of Pacific Islander and/or local backgrounds often spoke of their family's involvement in the local pakololo trade. Typically, their first experiences with pakololo occurred at very young ages. Exemplifying this early initiation, a Samoan man recalled his first high:

> *My family they are into growing it, and my dad thought it was best for me to try it when I was young. Only me out of my family liked it and hang with it. (504)*

> *I was anti-social and used that [pot] to further my rebelliousness against racism and emptiness in my life. My mom never even tried to curb my drinking. My mom drank and smoked pot, I remember her trying to get her parents to try pot in some brownies! (468)*

Similar experiences were reported in other sites with respondents stating that parental drug and alcohol use resulted in their own use of these substances at an early age. For example, one respondent reported that at age six he was already a regular drinker.

> *I had drank with my mom when I was 13 and 14. Regularly. Plus, I was taking her pills. We often drank cough syrup when we drank! ...I ...went away to college. I started getting a heavy crank habit then and began to drink a lot of whiskey with my crank. I drank 1/5th of whiskey a day then. (094)*

> *I used to get his empty whiskey bottles from the garbage can. He got me drunk on wine when I was 2 or 3... The first time I was drunk was in the 5th grade. I thought it was cool. I was curious. At first, I just did it. ... After that, I liked getting drunk, it made me feel good. I felt at ease. I got to like it. ...Then, two beers a night, then 1/4 of a pint every night. I was 14 or 15 at the time. (031)*

Thus, for respondents growing up in an environment where both parents had drug and alcohol abuse problems often led to a normalization of drug and alcohol use. According to one woman:

> *My parents fought a lot. Alcohol and drugs made it hard. I accepted it as it was, I didn't know life was any other way. When I was in high school, I started selling drugs. I was 15. Eventually my mom and dad split up and divorced. ...At that time, my dad offered me a joint on my 16th birthday, told me it was alright to smoke weed. I could get high with him but not take any from his stash! It was always reinforced that drugs were okay. I didn't do real good*

in high school, I was involved in making money selling drugs. I could sell one pound of weed in dimes in one afternoon at school! (255)

Another commonly reported consequence concerned the difficult and stressful lives endured by these respondents as children.

> *Both parents were alcoholics. My mother is a drug addict cause she did pills, too. Downers, uppers. Mostly downers though, and both of them had problems with drinking. They drank every night. ...it was very stressful. They fought all the time. They would not leave each other, but they stayed together and it was even more stressful.(094)*

2. Intergenerational Meth Communities

Not only did many respondents grow up in households where drug use occurred, we found evidence that these families were part of larger communities of meth users. These communities were found in all three sites, but were most evident in California in geographic areas where meth was produced. The significant place that meth has in the cultures of various communities in our study and the common perspectives shared by particular communities and regions underscore the importance of geographic location in determining access and acceptance (or at least ambivalence) towards methamphetamine. This was particularly pervasive throughout the Eastern portions of both the San Francisco and San Diego sites. Many of our San Francisco East Bay respondents recall their initiation and subsequent involvement (using, buying, selling, manufacturing) with meth in a cultural milieu composed of family, friends and other "locals" they had known since childhood. Often the phenomenon of "meth families" overlaps into fringe biker types as well as actual club members. Nowhere in America matches the longstanding tolerance and notoriety accompanying the manufacture and use of methamphetamine in certain East Bay communities comprising the Hells Angels home territory.

Despite their lessened involvement of the methamphetamine trade, they still instill respect and fear in working-class neighborhoods in both of our California sites. One of our East Bay "community consultants" attempted to convey the enormous influence still conveyed by the Hells Angels in a particularly notorious community where he lived:

> *The whole biker mentality, born to be wild, get your motor running and we're not just talking about the Harley is, that whole mystique has always been all over Richmond and San Pablo. The Richmond Hell's Angel's are about the most notorious chapter in all of Hell's Angel's land! They carry a respect and an awe that started from the wrecking crew of days gone by! Who knows what they're into now! I see them once in a while, they cruise by, they check out the territory, make sure everything is quiet and nobody is shooting each other that doesn't have permission to shoot each other! Kids grow up in this mentality. A lot of them, their dad's were Hell's Angel's. I know people who they're fathers committed suicide to get their families out of the whole clutches of what was going on at that time with Hell's Angel's. They grow up in this mystique and part of that mystique is that you're gonna carry a bag of crank with you. You're gonna wear black leather, you're gonna have a wallet with a chain on it (CC #4).*

Individuals growing up in these "meth communities" often share a "considerable local tradition and language" which Criminologist Elliot Currie observed in his research with juvenile drug abusers detained in a particular East Bay county (Currie, 1991). Interviewed as a "community consultant" early

on in our study, Currie described methamphetamine as an "endemic drug" whose use

> *goes back a long way in some of these families. It's very well known. The kids have grown up with it, known about it all their lives, parents quite regular users, often for utilitarian reasons...What did surprise me was the frequent stories of having been turned on to it by their parents. (CC #2)*

Decades of use of this product for such occupations as trucking, construction and factorywork have resulted in methamphetamine being seen as more acceptable than other illicit drugs of foreign origin (such as cocaine or heroin), which are also identified with disliked or threatening minority or "outsider" groups.

D. Arenas of Initiation

1. The Family Connection: Parents, Siblings, Uncles, Cousins

Respondents often provide graphic accounts revealing bizarre motives and intense experiences in recounting occasions of initial use involving a close relative. Very often, they essentially would be initiated into an existing subculture of use or dealing within the family. A 30 year-old San Diego woman lamented that her "*childhood went by fast*" as her parents sought to actively include her from an early age in their increasingly diversified drug trade. By the age of five, she "*can remember breaking up kilos of weed with my dad.*" (255). Shortly after her mom turned her onto cocaine for the first time, her father decided she would enjoy the crank he was beginning to deal instead:

> *I was at my dad's house and he had just gotten off from work. He told me to try this stuff that wasn't coke, it was crank methamphetamine stuff. I tried it and it was great. I snorted it at first until I almost blew my nose out. (255)*

Although the father of a San Francisco Bay Area woman was one of the largest drug distributors in California, it was her mother who was a very heavy IV user of cocaine, heroin and meth who first turned to on to the drug at age twelve.

> *My mom was sitting there on the bed and she had this nightstand where she always like kept everything. And I asked her, 'I want to know what makes you feel so damn good?' ...I want to know what's this shit that you're on that makes you just like fly around the room and not think about yesterday or the day before.' ...I said, 'Because I want to do some.' So she threw me a bag, she threw me an outfit, and she pointed toward the bathroom where the water was. So I went and got some water and I asked her, 'How do I do it? ... And she says, 'Well, if I have to tell you, then you have no business doing it.' And so I put like 25 units of water on it, squirted it in there. It come back to about 62, 63 units. And I said, 'Well, I can't do all of this.' And she says, 'If you squirt it out, then you don't have no business doing it.' So I did it all. And at 12 years old, I did about 63 units of it. And back then, it was like crystal meth. ...It was good, uncut stuff. I puked, I thought I was gonna die. I thought my heart was gonna come up out of my chest. It's like I thought I was gonna pass out. ...And my mom...says, 'Now, do you want some more?' And I told her, 'No, that's okay.' She goes, 'Okay, I'll see you in about a week.' And she was right, 'cause I spun out of there and I didn't come home for about a week.(092)*

Other family members also played prominent roles in initiating and/or supporting respondent use of meth and other drugs.

> *My cousins saw me partying and turned me on to meth. They been using meth all their lives, they're like 42 now.... They turned me on with meth, just lines at first. I was 14. We were in a garage. You don't take meth in a house, you take it in a garage! (430)*

> *My brother. It was in a hotel room. He was all tweaked out of his mind. He offered me a line. I did it and I liked it. I wouldn't do it all the time. That was quite a while ago! ... We was in a joined hotel room and the rooms joined together, there was a party going on. I just walked in and they were doing it on the table. I already saw it so he invited me to try some so I did. (116)*

2. On the Job Initiation: "Fringe Benefits"

In areas of widespread distribution such as those along the West Coast, there is a greater tendency among certain working class to use methamphetamine initially on the job. This was commonly cited by respondents employed in certain occupations such as trucking, per-piece work or other intensive labor such as the construction industry. In addition, others cited the benefits of meth in helping them survive and even enjoy otherwise monotonous jobs and/or graveyard shifts.

One El Cajon man described how he and his friend were introduced to "peanut butter crank" by his ever-wired boss to increase productivity:

> *The first amphetamine-type thing I ever did was, I think I was 18 and a senior in high school and I was working in a waterbed manufacturing place. This guy who ran it, the manager, used to come out on the floor of the place and do the same job you did. He'd stand next to you and he'd do the job you were doing. He'd do it 100 times faster! He said "See, I'm 35 years old, I can do the job way faster than you and you're only 18!" This guy was wired out of his mind! The first thing he'd do in the morning was put a bunch of peanut butter crank in his coffee and then all day long, he'd be doing spoons of crank! Finally, he decided to up the production on the floor and he started giving me and my friend spoons of crank. I can remember, even after work, I'd go home and be wired! I didn't really develop a taste for it. I didn't crave it every day. (205)*

A similar account was offered by a Latino male living in San Diego:

> *I used to work nights and that's what really got me started. My boss had it all the time on night shift and he'd give me a line. After work I'd go home and couldn't sleep. Come back the next day tired and had no other choice but to do another line. I'd stay up for 5 days at a time. I lost a lot of weight. Like 50 lbs. (248)*

Another Latino respondent in San Diego turned to meth on the job to modify his heroin use:

> *When I first started using, I was working night time from 11 till 7 in the morning. That was one of the main reason I started shooting crystal or any kind of stuff that was the opposite to heroin. To keep me awake. (206)*

An 18 year old caucasian living in Honolulu had few preconceptions about Ice when he was offered it by a fellow coworker:

> *I had only known this guy a couple weeks and I was helping him move. During the move he broke out his pipe and I didn't know what ice was. I thought it was coke at first. I had never seen it before. He asked me if I wanted some and I said yes. I asked him what it was and he said ice. I had heard about it but I wasn't too sure what it was. But I tried it and I liked it a lot. I was able to work faster and work a long time. I liked it a lot. I started hanging out with him and spending my paychecks on ice. (403)*

An African-American Veteran described two separate "initiations" in which he tried meth in very different circumstances overseas and at home. Back from serving a tour in Vietnam, he was struggling to survive the monotony and fatigue of the graveyard shift in an East Bay factory. A work buddy offered him some "crank." Partaking in this time-honored local tradition, he found meth to be a welcome change from the "depressing" experience he felt from both snorting and freebasing cocaine:

> *I snorted a line, it burnt from my nose to my brain! I said "What is this shit?" About 5 minutes after that, I was zinging! Whoa!... It was like a boost. I knew it was crank, the guy told me. I felt good, alert, doing things on the job. I actually put myself ahead on the job, got so much stuff done that I could relax a bit. (088)*

This was actually his second experience with methamphetamine, the first one having taken place in Vietnam years before. It was there that he was introduced to an exotic, mysterious form of black market meth known only as "109." He recalled being turned on by his buddies as an aid in striving to stay alive during the War. Although other respondents had used meth in the military, he was one of the few who described using it for combat, a purpose for which it had been extensively used roughly three decades before in World War II. This prior experience was pivotal in his willingness to sample the "white man's coke" back home.

3. Spouse/Lover Initiation

Respondents often recounted how they were first turned onto meth by a lover. In many cases, their initiation came very early on in a relationship and for some it was part and parcel with the sexual consummation. Although women were typically more apt to be the initiates in such circumstances, a Korean man in his early 40s described how he was on the receiving end for his first experience with Ice. Despite having considerable experience with pharmaceutical and good quality bootleg amphetamine pills, he found himself blown away by his unusually intense introduction to sex on Ice:

> *I met a stripper and she liked me a lot. All we did was screw. I was in heaven, finally getting all the sex I wanted! She told me to try this powder she had, up my nose, to snort it. We did that for the next 10 months!... It was ice, crank, crystal, it was a combination cause you got it from somebody different almost every time. I liked that a lot! (453)*

Another male respondent reported snorting meth for the first time at his girlfriend's request.

I was going out with a woman who was using it. She hooked me up with it. We were dating. I snorted it the first time. I was about 15. She always had it, so I used it. It was free. ... I used about one gram a week off and on. ...Mainly sex. That was the main reason. She wanted me to try it for that reason. (101)

It was common in Honolulu for women users to begin use through men rather than another woman. Often, they were introduced by their boyfriends or their husbands. As this 30 year old Filipina described:

My first experience was with my husband, he introduced me to it. He showed me how to smoke it. We did good in the beginning. God, what sex we had! Go! Go! Go! ...We played cards too. Went fishing. But mostly sex. It was always good sex. (445)

4. Social Bonding: Peer Group Initiation

The motivation toward peer group bonding characterizes a common theme among Latinos in San Diego and Honolulu respondents from "local" communities. A Samoan man in his mid-20s echoed the perspectives offered by other respondents (particularly in Hawaii) in explaining why he decided to give Ice a try:

I started because I seen my friends doing it, just to be with the boys, you know. I had to try it, nobody forced me to, but, I just wanted to be part of the boys and I did it. (504)

A Latino user in San Diego had hung out with older boys, and attempts to fit in led him to his first drug use at age 9, and his first meth use at age 13. On that occasion being 4 to 5 years younger than his friends, made for a memorable first experience.

The first time was because my friend offered it to me. I didn't know what this powder was. He did a line on a mirror and I had never snorted before, I blew it all away with my breath! I sneezed and he got mad at me. But he gave me more, another line. I felt hyper when I snorted. I could taste it draining down my throat. I still remember that. (248)

One user admitted being scared at first:

I was doing something I knew I wasn't supposed to! I knew better, I was raised differently, my parents would have been so disappointed! I wanted to do it to fit in to the group that I was with. (266)

An 18 year-old Filipina recalled wild times with her girlfriends when introduced to ice at the age of 14:

The girls I hung with ruled! We were always in the principal's office, in fights, being jealous cause of guys. We got busted for alcohol in 6th grade. I still hang around these girls today, we're good friends. When I reached high school, they threw me out, big time. I cut school one day and went to my friend's house. Everybody there was smoking it. I wanted to try it and I did. I never went to sleep, I was tossing and turning all night. After I knew I couldn't sleep, I walked back to my friend's house and asked for more. She gave me some. I was hanging out with them from then on. Most of the guys I hung around with were dealers. I got ice from them, we used to smoke everyday, every night, too. Big party. (463)

An East Bay man in his mid-30s recalled a rather unique first experience which brings together many of the previously discussed temptations of growing up and working with peers and family who have gotten into meth:

> *I was 24 and I had a friend that I had known since I was age 16, 1980, and he had been using crank for a long time and we worked together, and it was a dangerous job, ... and I saw him make a number of mistakes, ... He can't make mistakes, if he does, he is going to injure people. ... And I saw him, I know he went into the bathroom and got wired one day because when he got out, he acted totally different, all juiced up, walked up to the, happy as can be. I told him he shouldn't do that man, how can you do that. ...he was a good friend. ...I was around crank all my life...and people I was around like older brothers or sister to me used it and I saw how they were, and I saw my friend becoming one of those people. ...just a wasted human being, ... I could see him changing. So I was at him for six months, .. and his standard reply was, how can you tell me to stop when you don't even know what it does to you. You could say it was a cop out or whatever, but that was the real reason I ever did crank for the first time. ...he fired it, the first time I did crank I injected it... I laid my arm on the table and pulled up my sleeve and this guy, this friend stuck me. (081)*

E. Early Impressions: Appreciation of Initial Use

A number of overlapping categories emerge from our analysis of the most prominent attractions noted by users in our sample. Respondents described feelings of energy, euphoria, confidence and disinhibition. They also described an appreciation for the long-lasting effects of meth which enabled them to stave off normal or drug-induced fatigue.

1. New Outlook on Life: Optimism, Enthusiasm and Energy

Many users described how meth eliminated the agonizing boredom associated with even the most monotonous types of labor. Reflective of many respondents, a 30 year-old woman described herself as a "white tornado" on meth, ready and willing to clean house for countless hours:

> *It got me wound up, I thought I was on top of the world. There was nothing I couldn't do when I was wired. I could clean everything! (070)*

A Bay Area respondent gave this detailed account of how meth changed his life by doing away with his depression:

> *I was really depressed in the early 70's. I was holding everything inside of me. My connection asked me to try this powder, he called it meth, I snorted it. After then I shot it. ...That brought me out of my depression. After the high was over with, I felt fine. The depression I had for years was gone! I felt beautiful and pretty. I felt like everything I should have been during the high... Not hungry. Energy. It felt wonderful. The best feeling I've ever felt. I sat down and thought I hadn't felt like that since I was 14. ... Pretty, successful, makes you feel really beautiful. Like I can achieve what I want to achieve. Also I had problems talking to my dad and if I did a couple of lines, I could talk to my dad! I could handle doing everything I had to do if I was on speed. It gave me that extra, needed touch. (094)*

Often the energy was accompanied by an surge of confidence. A 28 year-old Caucasian construction worker in east San Diego County described how the meth high provided incredible confidence and

> *...energy, you felt as if you could do anything you want, lack of fear, you think you can do anything. (296)*

A Honolulu respondent remembers a similar effect with his initial experience with ice.

> *I felt like Superman. I could do things that I didn't expect to or never thought of doing... Like walking on the edge of buildings, high up, not being scared. Who cares, if you fall, you fall! It was really weird. I felt more risky. Take more risks. (450)*

2. Clarity: Less "Speedy" Than Other Stimulants

One of the most significant findings revealed from this study is the significant proportion of respondents reporting histories of either asthma or hyperactivity in all three sites who also stated that methamphetamine had a calming or centering effect on their mood and/or behavior. This finding seems paradoxical to methamphetamine's reputation as a strong stimulant. Nevertheless, many respondents contended that they felt greater clarity and less "speediness" on methamphetamine than they felt with other stimulants such as cocaine and other amphetamine compounds. Like other asthmatics in our sample this user describes the effect of meth as "calming:"

> *I took that first hit and after I gave him back the pipe, I had an urge to grab the pipe back from him! I couldn't fight that feeling! Ever since that first hit, I've always had that feeling. Even now, just talking about it, I get the urge to grab that pipe! Just talking about it brings back that first feeling. I never forgot it. ... It felt great! When it went into my lungs, I felt this feeling like I was strong. Like I could go run around the block 20 times! Instead of getting me up, because I'm asthmatic, it had an opposite affect at first. It calmed me down and slowed me done. ...Most of the time I was able to sleep normally. It was when I mixed it with asthma medicine or cocaine freebase, then I'd get a mean rush! The mix of meth and cocaine would keep me up. ...Sometimes I'd get a feeling of soberness, sometimes a feeling of strength or euphoria. It was never disoriented, it was always a feeling of clarity. (468)*

Another respondent reported a similar effect, only this time in relation to effects from heroin.

> *I don't know but that's why I like heroin cause I got down to 160. But not on speed, and it was weird cause I would sit around on speed, but heroin, I would move around. (292)*

3. Sex: Disinhibition and Duration

A Honolulu respondent describes his first experience. He was turned on to ice by a stripper, and continued because of the great sex they had.

> *I met a stripper and she liked me a lot. All we did we screw. I was in heaven, finally getting all the sex I wanted! She told me to try this powder she had, up my nose, to snort it. We did that for the next 10 months! (453)*

For a woman user in San Francisco her first meth was injecting liquid ampules in the mid 1960s. She had no doubts about it sexual effects:

> *...when a woman does a hit of crank, a woman comes. Climaxes! Every woman who has ever done crank, that happens. That's why so many women like it. Unlike men, who climax every time they ball, that doesn't happen with women. It's something that nothing else does. (055)*

A gay male hustler described similar effects injecting the drug the first time he used meth.

> *The first time I was in Oregon at a friend's house. There was a party going on and I heard about all these wonderful experiences about doing speed. Shooting it up and these sexual feelings that went with it. I wanted to try it. My friend fixed me up a point and I did it. The feeling and the rush was so incredible, intense. I was running around trying to have sex with everybody! I ended up waking up the next morning down stairs in the garage. (035)*

In fact, for many gays this first time was the only time they became so disinhibited, for others as we report in subsequent chapters, it led them into more erotic activities. The respondent who got introduced by his brother, stated that it was the first time he felt homosexual feelings.

> *Yeah, but I couldn't really get it up and I was staring at my brother and I didn't know why. My brother did bad things too; he used to like to play with me and stuff. When he was high. Even when he wasn't high, when we was kids, he'd touch me and stuff. ...that's the first time I really thought about it. In a homosexual way. (116)*

4. Pure Pleasure Experience: Enamored by the "Rush"

Commonly, respondents reporting a special attraction to the rush during initial period of use were IV users. One male recounted how the anticipatory excitement which followed his explosive initiation to meth via injection of a monster one half gram dose:

> *I kept thinking and wondering if that would happen again when I tried it. I couldn't wait to try it again. I had never felt anything like that before or since then! (093)*

An Asian woman, who is a long time experienced user in San Francisco describes what happened soon after she first experimented with meth:

> *It was 1965. My first time with needles. I was 15 years old. I was having these Hells Angels guys fronting me a gram. I had two boyfriends who both used needles, I didn't at the time. They showed me how to shoot. They sat me in a big arm chair and turned on Lou Reed music. They both simultaneously hit me in each arm. It was a killer rush! I couldn't believe it! Before I was just snorting and with snorting, you got really speedy but it wasn't like a needle. This was really euphoric, warm and sexual. (114)*

Another respondent who experimented early with IV meth use, provided this vivid description of the effect:

> *He hit me and the top of my head flew off! I broke out in a sweat. I couldn't feel the bottom of my feet and I was walking like I was goose stepping. [I thought] this is my thing! (091)*

F. Summary

With the exception of those beginning their meth use in the 1950s and 1960s, we found very little variation by gender and across sites in rationales and circumstances for initial methamphetamine use given by our respondents. Similarities in family background, work and peer group experiences framed the environment for beginning use and provided motivation for continued use as well.

TABLE V-1

PARENTAL ALCOHOL AND DRUG USE: BY SITE AND GENDER
(Number and percent of respondents answering yes)**

	SAN FRANCISCO		SAN DIEGO		HONOLULU		
	Male N (%)	Female N (%)	Male N (%)	Female N (%)	Male N (%)	Female N (%)	TOTAL AVG N %
	86 (97)%	40 (100)%	87 (98)%	43 (98)%	83 (93)%	40 (98)%	N=380 (97)%
	37 (42)	13 (33)	43 (48)	13 (30)	45 (51)	22 (54)	N=173 (44)
D	19 (21)	10 (25)	18 (20)	13 (30)	16 (18)	12 (29)	N= 88 (22)
	17 (19)	5 (13)	17 (19)	6 (14)	17 (19)	16 (39)	N= 78 (20)
IN	8 (09)	3 (08)	6 (07)	3 (07)	6 (07)	0 (0)	N= 26 (07)

RCENTAGES MAY NOT ADD UP TO 100 DUE TO ROUNDING

CHAPTER VI

USE DYNAMICS AND TRANSITIONS: PATTERNS, RITUALS, RULES AND FOLKLORE

A. Introduction

The considerable duration and involvement with methamphetamine commonly seen in our sample underscores the "career concept" as a useful explanatory construct in assessing respondent use over time. At the time of interview, most respondents continued to be active consumers (and purveyors) of methamphetamine, albeit at markedly different "stages" in their use "careers." Many respondents had undergone significant transitions over the years in their usage patterns, modes, motives and contexts. The meaning and value attached to the meth experience evolved over time along with a growing body of user folklore, rituals and rules to guide respondents. This chapter examines the differing rationales, routes and rules which often accompany changing use patterns and transitions.

B. Role of Other Drugs

As discussed in Chapter IV, almost all of our respondents had considerable experience with a variety of illicit drugs and with alcohol. (See Table IV-5). Our findings reveal a significant reduction of use of these drugs among those who reported prior lifetime use. Respondents with any lifetime use of the substances listed in Table IV-5 were asked the number of days they had used those drugs in the six months prior to the interview. The results shown in Table VI-1 show a marked decrease in use for each of the seven substances listed in Table IV-5: alcohol, marijuana, powder cocaine, crack cocaine, heroin, tranquilizers and psychedelics.

1. Methamphetamine and Alcohol

Most of our sample continued their use of alcohol. Table VI-1 shows that only 22 percent overall report not drinking in the six months prior to the interview. Respondents in Honolulu were significantly more likely to report regular and frequent drinking with 41 percent using from 61 to 180 days during the past six months. This compares to 29 percent in San Francisco, and 36 percent in San Diego who reported drinking at that level.

Some respondents described their continued use of alcohol to counter the meth speediness. For others, drinking was the primary goal and meth expanded their ability to drink, or to "equalize" the effects of heavy alcohol use. Some only did methamphetamine when drinking. One San Diego male user stated, for example:

> *I never decided to do it. I just ended up doing it. It wasn't like I wanted to keep on doing it. Usually I never did it unless I was drinking, drinking first. ...you get buzzed and do lines...and you can go out and get drink after drink and socialize. (251)*

A lesbian IV user gradually evolved from pills to snorting to IV use in order to be able to drink and maximize the high:

It always enhanced my drinking, cause drinking was my number one thing. It burned; it tasted nasty! But I liked the initial rush that came to my head. There was instantaneous clarity. I'm awake and I can do this! Drinking was always along with it. The rush and being able to drink more. (280)

A Honolulu respondent reported that this was the major reason he overcame his fear of smoking ice:

After I tried it, it was just like smoking coke! It give you a more up type high. You can drink more, smoke more, you can party more because the ice keeps you up and pumping! (517)

According to a heavy IV user from San Diego, methamphetamine was also "the great expander" of the effects of whatever other drug used with it. For her, that drug was usually alcohol.

Meth is an expander of whatever other drugs you're doing. Meth will stay the longest and be the last to leave. Meth has the longest legs. It doesn't necessarily have the biggest or longest rush, but the combination of the others never covered up the fact that meth was always there in my body last. Meth enhanced the other drugs. It makes them much better! ...With alcohol, you're sick...but with meth, I don't have the alcohol hangover. Meth covers the toxic value of the alcohol. I could drink again, so I would. Meth lets me drink more. ..I could drink alcohol like water. And I would think it wasn't hurting me because the meth said "No, you're fine!" (286)

For another respondent, his early alcoholism was a major factor in his regular use of methamphetamine.

I used to do crank and drink with all the big boys! Finally, I got to be a full blown alcoholic and I drank all the time, just to drink! From the time I woke up until I went to bed. In order to be able to handle the alcohol, I did crank cause it kept me straight. I used alcohol and crank to counteract each other. (031)

The qualitative depth interviews also revealed that some respondents developed a dislike for alcohol after prolonged use of meth. This is illustrated by examples from the following users:

One thing the ice did for me was that it made me quit drinking. I used to drink a lot with cocaine. I could party all night with alcohol and coke! When I went into ice, right from the very start I didn't want to drink. The ice cured the taste for it. ... Maybe in a month I'll drink twice. That's it. Before it was like I was an alcoholic! Nonstop to where I'd pass out and not remember. All of that is gone. That's one good thing I can say about ice. (449)

I used to drink a lot when I was on speed, years ago. I could drink more! Now, I don't even like the taste of alcohol! I have no desire for any other drug except speed... Sometimes I'll use a little bit of heroin. (093)

2. Methamphetamine and Marijuana

Most respondents with prior marijuana use experience continued to use during the six months prior to the interview. As seen in Table VI-1, approximately three fourths continued using in the San Francisco and San Diego sites. In Honolulu, however, where pakololo has been increasingly difficult

to find, over a third had discontinued use in the six months prior to the interview. In Honolulu, the relationship between marijuana and meth were considered quite differently. For example, one user described the reasons why he switched from smoking pot to cocaine and finally to ice. When asked if he still smoked pot he replied:

> *Yes, I still do smoke. I cut back smoking a few years ago because there's hardly any around! The police pull it out so marijuana is hard to find. That's when cocaine started coming about. The rocks. I was snorting cocaine at first. Then I tried smoking the rocks. Oh, then it became a habit. (460)*

Another Honolulu user went through a similar process from smoking pakololo, to smoking coke, and finally to ice.

> *I liked the ice because it lasted so long. It was a considerable amount longer lasting than coke. But if I only had so much money and there was no way to get more, then I'd buy marijuana. That was cheaper than ice and I still liked smoking weed. (403)*

Many users in Honolulu quit using, simply because the price became to high for most of our respondents to afford.

> *[I used to] buy joints for $3 or $2. Now, it's $5 a joint! If it's shake or leaf, the price is different. Hash is for $5. Buds are more expensive. Not anymore now. (463)*

3. Methamphetamine and Cocaine

As seen in Table VI-1 over half of those reporting prior use of powder and/or crack cocaine had quit using completely. This was highest among prior users in San Diego with 70 percent reporting no use of powder cocaine, and 72 percent no use of crack during the past six months. In San Francisco, among prior users, 61 percent had discontinued use of powder cocaine, and 55 percent had not used crack. Fifty-nine percent of prior users of powder cocaine, and 57 percent of prior crack users in Honolulu reported no use during the six months prior to the interview. However, it is interesting to note that Honolulu respondents were more likely to report continued use with 14 percent reporting 61-180 days of powder cocaine use during this period compared to 2 percent in both San Francisco and San Diego. There were similar differences between Honolulu and the two California sites for crack cocaine as well.

The rationales for discontinuing cocaine use are found in the depth interviews where respondents also described many reasons for preferring methamphetamine over cocaine. The exceptionally long duration of action was commonly cited as a primary reason. The cost effectiveness of the long-lasting meth high was described as a major advantage over cocaine. This was particularly true for mainland users where gram prices of the two drugs were roughly equivalent. Comparing I.V. speed to I.V. coke, a mainland respondent summed up the opinions shared by many others:

> *I don't like it. You just get rushing and it's gone. I like something that's gonna give me the energy to go out and do things. Run around, have fun, not have to fucking go out and do, instead of $300 or $400 bucks a night, you spend $ 20 to $25 bucks. You're satisfied, you know? So you don't have to, it's not to where you have to worry about how you're gonna do it, it's easy to support yourself with it, support your habit. If that's what you want to call it. (118)*

In Honolulu where the price of ice was much higher, respondents still recognized the cost effectiveness of the longer lasting ice high, especially when combined with more desired effects. For example:

> *I stopped doing cocaine because it was too expensive. The crystal meth was cheaper so I changed. Once I started doing crystal meth, I didn't really care for the coke anymore. It obsesses your mind, where you want the crystal meth. You crave for it. I don't know why, but it doesn't make you feel good, it just makes you stay up. [with ice] You do more things. I liked fixing things. (528)*

Respondents also cited other qualities of the methamphetamine high as well. For example, those suffering from asthma perceived the meth high to be less jittery than cocaine. For example, a 41 year-old Hawaiian respondent who suffered from severe asthma provided this appraisal:

> *Prior to being introduced to meth I was doing coke and I really didn't like the high, it was, I don't like to get jittery, and when I used to smoke cocaine, free base, I could feel my heart racing and that would make me feel uncomfortable. When I do ice, it's like, it's a gradual high. (444)*

Another Hawaiian, who also suffered from childhood asthma, provided a similar comparison:

> *Well, I get into trouble. I did more bad things when I was doing coke, more mugging, rolling and robbing on coke than since I switched to ice. Ice keeps me relaxed, calm, not as paranoid. Unless I over due it. As long as I do my limit, I can handle the ice better than the coke. (535)*

A San Francisco user, however, reported the opposite effects as the reason for choosing meth over coke.

> *The coke high is a lot mellower. You can sit back and watch TV... With crank, you want to get up and move. Gotta do something!(070)*

4. Methamphetamine and Heroin

Table VI-1 shows significant differences in recent heroin use between respondents in San Francisco compared to the other sites. In both San Diego and Honolulu three-fourths of the respondents with any lifetime heroin experience had discontinued use. In San Francisco, however, only 41 percent reported never using in the six months prior to the interview.

In contrast to the relatively minimal experience with heroin in the other two sites, many of our veteran San Francisco respondents also described lengthy heroin "careers," and some were already addicted to heroin before they happened onto or pharmaceutical methamphetamine ampules or clandestine "speed" on the street. For these users, methamphetamine typically became an addition, rather than replacement, to their regular opiate use. However, others reported turning to meth to help kick their heroin habit:

> *It took me awhile. I turned green. I was like wanting it so bad I'd roll up in a ball and my stomach felt like it was just being turned and twisted and knotted. And I'd dry heave until I*

couldn't dry heave any more. But the beer and the weed helped level off the down syndrome, making me feel, 'Ughhh.' And then I would do a hit of speed a day. I didn't want to overdo with speed that would make me want more of the heroin. (092)

5. Methamphetamine and other drugs

Over three fourths of prior psychedelic users in San Francisco and San Diego, and 86 percent in Honolulu, reported they had discontinued use. There was less similarity regarding recent use of tranquilizers across study sites. Less than half of those reporting prior use of tranquilizers in San Francisco had discontinued use, compared to 61 percent in San Diego and 63 percent of the smaller number of prior users in Honolulu. Furthermore, respondents in San Francisco were more likely to continue using on a regular basis. Several respondents explained that meth seemed to fill all the gaps that previously required the use of multiple substances. This was commonly heard among Honolulu users. For example:

I was a heroin addict; I liked downers; I was a pot head; I was a speed freak; I was an alcoholic. Ice just seemed to top everything. Why? I don't know. It topped everything. I loved my heroin, but ICE topped everything and became number one. If I go back to smoking ice, everything else would become a chain reaction to ICE. I'd begin heroin and downs again, booze, pills, drink. (525)

On the other hand, the eventual preference for meth may be simply a matter of direction. As one San Francisco user rationalized:

Speed is more vertical and downers are more horizontal. Marijuana and alcohol put you in another side of your state, speed takes you forward. (115)

C. Modal Transitions

A wide variety of modal transitions were experienced by our sample. Those respondents who did not transition to other forms of use, generally fit within the most common mode in each site. These included ice smokers in Honolulu, snorters in San Diego, and IV users in San Francisco. For the most part the evolution of modal transitions were closely linked to the environment and time period of their initial use.

1. Transitions from Oral Use

Many went from oral use to intranasal and eventually to injecting. Others, especially long-time users in San Francisco transitioned directly from oral to IV use. At the time of interview, injection was the preferred route of administration for most of the long-time users in our sample. With the notable exception of those who were already I.V. heroin users at the time of their introduction to speed, many others recalled a period of time in which they relied solely on oral ingestion with little thought of the needle as an option. For many, the transition from swallowing to shooting speed corresponded with the transition from pills to powders on the street which began in 1963.

An African American respondent recalled being introduced to amphetamine pills shortly after his return to the states from serving a tour of duty in Vietnam. Although he enjoyed the effects

provided by oral ingestion, his search for new experiences soon led him to the intravenous option, several months after his initial use of speed.

> *There came a time that I began to shoot. I let one of the guys inject me. I recall immediately enjoying the intensified freedom and it's something I liked immediately...As time went on, I used speed on a regular basis, about a half gram every two days. (025)*

2. Transitions from Intranasal Use

In contrast to respondents who had few qualms when first injecting meth, others felt a mixture of curiosity and fear about I.V. use. While some were working up their courage and desire for some future rendezvous with fate, others made transition in a less rational manner:

> *I was drunk. A guy drew it up for me and fixed me. I sat there too plastered to stop him. He did it to me and that was it. It wasn't something I chose to do. I had thought about doing it before. But I never had. (094)*

Some respondents switched from snorting to smoking. One main reason was to get away from the burn associated with intranasal use.

> *I liked the feeling but I didn't like the burn. He told me lots of people smoke it on foil. ...and he showed me how. That was more of a mellow high for me than snorting it. That's when they had the heavy duty aluminum foil, the thick stuff. I got to liking it. (088)*

There are indications that this less painful method of rapid uptake is slowly gaining in popularity as more users learn how to smoke with a glass pipe rather than foil, thus eliminating the bad taste of the foil and increasing the efficiency of use. This is a way of bypassing the nasal pain, and yet not using a needle.

> *...it's [smoking] pretty common in people who have been snorting it for years and seems like their nose is fucked up and yet, don't want to shoots. They draw the line there. It works, works fine, smoking it. (001)*

3. Reverse Modal Transitions

Some users reported going back to snorting meth after their IV use caused them to loose control. These were seen as attempts to skirt the fine line between functional and dysfunctional in attempting to negotiate between the "outside" or straight world and the "meth" world.

> *I did shoot crank for maybe two months after that time he shot me, but it wasn't the same high. It didn't give me the same feelings and it made my heart beat too fast! I couldn't pass in normal society when I shot crank. I was still holding on to the threads of normality at this time. To pass in normality I had to snort it. ...If I shot it, I didn't feel beautiful. Snorting it made me feel beautiful, it's really weird!" (094)*

Other respondents switched from IV use to smoking, either for health reasons or in an effort to regain control over their use. In general, however, there were few respondents in the overall sample who transitioned back toward more moderate routes of administration.

D. Evolving Use Patterns

Following initial experiences with methamphetamine, respondents described the gamut of subsequent use patterns. At one extreme were those who promptly plunged into binge mode and scarcely looked back. Other respondents were unimpressed with their initial experiences with meth or satisfied with occasional dabbling. Respondents found their consumption of meth escalating as their reasons for use expanded to more and more activities. Many found themselves increasingly using meth to provide a needed "boost" in keeping up with the gamut of perceived demands. Meth use for work or play often increased to forestall the inevitable burnout from overuse.

1. The Strategic Use Continuum

Although most respondents tended towards irregular binges, there were also others who engaged in much more systematic patterns of use. This often took the form of a standard daily regimen, which resembled common patterns of coffee use. As with coffee drinkers, some respondents would increase or decrease their usual dose of meth as needed.

> *My use is starting to change a little bit, too. For the last couple of months. I used to use it for projects and for excursions and now that I've found myself in a transition period of working several different jobs and trying to get some jobs off the ground so that I can drop off one job, not having enough time to sleep, I use it like coffee. A small snort in the morning, just to carry me thru. By the end of the day, I'm able to get my energy level back to where it was to normally go to sleep. (115)*

A 23 year-old San Francisco mother controls her repeated use throughout the day by allowing enough time--and downers, if necessary--in the evening to burn out and sleep:

> *It takes about three minutes to work after I snort it. It hurts my nose at first then it clears up. You sit there and wait for it. Sometimes my hair will stand up and I'll feel a little light. Then I'll immediately feel good and normal! That lasts for as long as I have it. I continue it. That's why I often make myself go to sleep on it cause if you don't sleep on it, it's not the same high. That's why a lot of people don't enjoy it as much, I think. (094)*

Another mother goes through approximately 18 grams a month, while claiming to maintain control over her daily dosing regimen. A former I.V. heroin and speed user, now on methadone, she typically ingests oral doses at strategic times of the day. She describes how she is able to attain a level of function and control which enable her to reach a level of self-esteem and productivity on a consistent basis with heavy regular use:

> *Typically, about three times a day. Once in the morning, then usually after my nap with my son and then again in the evening. I think that I function better now than I did. I tend to be*

depressed and speed eliminates that. I like to do my housework, to read, be with my son. ... I like to act as much like a lower middle class home as I can get. ... It's the only time that I can maintain a job is when I'm doing meth. It's very positive for me that way. (126)

We found several respondents who used primarily for specific occasions, during their early years of use. A common reason was for school.

Mid-terms always came up, we crammed on crystal. By my second year, everyone in my dorm was on crystal. ... A basic chronological pattern would be February of 1985 about twice a month. Using 3 days in a row. ...We'd get high and study, take a nap, get high and study, take a nap. get high and study. Crash finally. (311)

2. Binger Continuum

Most of the respondents in this study found it difficult to use methamphetamine without eventually evolving into some form of binging pattern. As Table VI-2 demonstrates this was true for respondents in all three sites. During the 12 months prior to being interviewed, only 5 percent of respondents overall were able to use while maintaining a daily sleep pattern. This ranged from a low of one percent in Honolulu, to 3 percent in San Francisco, to 8 percent of respondents in San Diego. A typical "use episode" involved three or more days without sleep for over two-thirds of our sample in San Francisco, 54 percent in San Diego, and 60 percent in Honolulu. Of these an astonishing percentage reported going seven days or more without sleep when they used meth. This occurred most among Honolulu respondents with 17 percent, followed by users in San Francisco with 11 percent, and San Diego with 7 percent.

Many respondents followed a characteristic "weekend warrior" use pattern. In so doing, they attempted to engage in extensive methamphetamine binges without interfering with their work or school during the week. Although this remained a common pattern for some respondents, most had experienced the tendency for "weekenders" to encompass much more than two days. This became particularly evident when the long lasting residuals from the burn out interfered with productivity during the week. One respondent, for example, spoke of this pattern beginning with snorting less than a half gram per weekend:

...in a social situation. A weekender...for about five years. Then my use increased. Depending on the job situation at the time, I could get away with using it at work, maybe. ... I've never done anything every day. But, quite a few times more than just on the weekends. Maybe several times during the week. (125)

Other respondents spoke of similar patterns of overuse on the weekends.

I'd be out all night drinking and get so tired. My work performance got so bad. If a machine broke at the printing company, normally I'd fix it in 10 minutes or call the repair man. On wire, I'd spend six hours tearing the machine apart and breaking down the motor. ... Sometimes I'd be late for work cause you stop being responsible. Days I didn't want to go in cause I'd been up for two days. (070)

Almost all of the substantial proportion of respondents who began using at their place of employment, soon expanded the site and the motivation for use.

I started doing speed on my first job. working for an airline, I worked for them for 11 years. I started doing speed in 78. When I was snorting it, speed wasn't that much of a problem. When I started shooting it, it doesn't work! At first I did two hits. One right after I got off from work and another hit the next day. After a while, you do more hits and it begins to eat into my work week. I got so I couldn't handle work! It was too overwhelming. I was late, I didn't show up...(124)

Often these escalating use patterns created a lucrative, demand driven market for anyone who had the supply. One of our respondents described how he and a friend began putting a little crank in their coffee at the start of each work day on a construction site. However, this regimen soon escalated after;

...the whole construction company found out that I was getting some of the best crank in town. It's a working man's marching powder. Pretty soon, I was running back and forth from the job site, picking up loads of dope for the whole construction crew! So, before too long, I was involved in daily use. After a point in time, I gave up the job altogether. I figured, it cuts into my drug using time! I will chase a bag from now on, that's my job! (010)

With escalating use, some heavy bingers increasingly gravitated towards daily or almost daily use of large amounts allowing only occasional brief periods of rest and recuperation. A surprising number of respondents reported that they only began to reach their desired high after several days. A San Diego user offers this detailed description:

My goal at this time was to stay up for seven days and for the first two days my behavior was really normal and I didn't feel like I was getting off on anything. ...[using] a quarter at a time, IV; maybe two or three times in 24 hours and I would stick with that steadily and then towards the middle of the week I would start getting really noticeably high, where my movements were erratic and my pattern of thought was really screwed up and then towards the end of the week it would be where I would really start getting into the high. I would be having physical sensations of being high, like the nerve endings tingling. The unbearable point where I end up going to the Baths or spending like three days locked up in my apartment in front of my VCR... Then I would crash for two or three days and somewhere after six months to a year of doing this, sometimes I would get sick towards the end of the week, if I tried to do 8 or 9 days cause it got to the point where seven wasn't doing it anymore. (278)

This pattern is also typical of many IV using respondents who tended to embark on "runs" which typically last at least a couple of days and often much more. Many of the more hardcore respondents describe use patterns and behaviors which are strikingly similar to those of the "Speed Freak" who emerged a quarter of a century before in San Francisco's Haight Ashbury Subculture. (Kramer, Fischman and Littlefreld, 1967; Cary and Mandel, 1968; Smith, 1969).

Although, many respondents seek to rediscover the peak experiences which accompanied their initial use, heavy bingers, on the other hand, take the shorter view in attempting to reexperience the peak high found at the beginning of a particular "run"--often chasing it or striving to recreate/prolong it for ever briefer periods with ever larger and more frequent "hits."

E. Intrinsic Influences on Continued Use

The same qualities which make meth such an attractive work drug also make it desirable for other life pursuits (except sleeping or eating) as well. Despite differing motivations and circumstances surrounding their initial use, respondents generally shared a common appreciation for certain qualities of the methamphetamine experience.

1. Body Image

The weight-loss attributes of meth was contributed to enhanced perceptions of physical appearance according to a substantial number of women users. A woman who had recently discontinued use, recalled how injected methamphetamine kept her slim:

> *I'm 5' even, for the last ten years my average weight was 105 pounds. Now that I'm clean, I weigh 130 pounds. To me, that's a little bit too much. I'd like to weigh 120 pounds. Because of using meth all the time, lots of it was for weight control. I'd have my kids, boom, I'd be back on the wire. I never breast fed because I had speed in me. I'd get back to my regular size in two months after the kids were born. I never ate a whole lot, I cooked and never ate much of what I cooked. The speed kept me slim, I was fat when I was a kid. The doctor put me on a diet and I never dug that. So, speed was cool. (126)*

Another woman talked about the various ways meth helped her get thin.

> *I was still taking thyroid medicine, that got my weight back down. I realized that I could lose more weight if I stayed up all night. I'd have a meal and then do a line. I was also working out, doing aerobics and running 6 miles every day! I always have done that. Sometimes, I thought my heart was gonna fall out of my chest! I loved running on crystal. (311)*

A 23 year-old San Leandro woman reported depending on meth since her first use at the age of 14, to alleviate two interrelated problems:

> *I used to be heavier and I was really depressed about my weight. I think another reason I do drugs is low self esteem. (002)*

2. Psychological and Emotional Changes

Many respondents reported they continued their use of meth because it satisfied an emotional or psychological need. They found that, with continued use, they could achieve a desired state of well-being and/or emotional stability.

> *... crystal made me really go! Completely outgoing! At times, it made me over confident. Confident in areas that I wouldn't have been confident in before. (335)*

Very often the desired psychological state was one of emotional distance. Respondents in all sites reported that meth helped them to feed emotionally detached from the pain and struggle of their daily existence. A 27 year-old East San Diego county male summed up methamphetamine's emotional effects well:

When I do a line, I lose depression. I forget about things, I get more involved with other things (266)

Sometimes, when I don't want to be depressed or melancholy, I know that I can get the euphoria and at the same time become detached in emotional ways, it really does occur. ...in a way, it makes you a little bit, it does cut off emotion. It does make you hardened to emotions. (115)

You get tired, it suppresses your emotions. You get flattened out. When you come off the drugs, the tears come out cause they get totally suppressed. (063)

An important rationale for continued use among a number of respondents was methamphetamine's ability to alleviate the negative aspects or fill in the deficits of their personalities. A Latino male in San Diego provided a personal rationale, explaining that after a prolonged period of use, the peak of the high had lowered into a more modest goal:

Well, I use it cause I just want to get normal. I just want to wake up and feel good. (247)

Many respondents actively resisted immersion into the "meth world" by alternately maintaining some distance from it as well as preserving or regaining their stakes in conventional life. For one man in his 50s this was achieved by the meth high.

It's like being normal. That's like being invisible. You get higher than the rest and nobody knows it but you! Drugs are a very private thing in the mind, you know? (093)

I feel good. It energizes, motivated, enhances your mind. You can think of things, if you're artistic, all that comes out in you. Willing to do more things, opens you up a little bit more, you can, if you're a closed person, it opens you up a little bit more so you, it's not just, you know? (118)

However, we found this to extend beyond this group into a wider range of users, across all study sites and in most ethnic groups. A respondent in Honolulu offered this definition of these users

A lot of nice, kind people I know were very intimidated and kind of afraid to show their real feelings. That's why they were so kind! I found that when they are on ice, they wasn't afraid of that. It didn't have that block anymore. They just full came out. Right away they started telling "You know I really don't like you! Honestly, I really don't like and I'm not this nice!" I also found out that in a few cases that it helped a lot of people too; to come out of their shell, to advance in their work, in their careers, in a lot of things. (413)

Many respondents who reported being diagnosed as hyperactive in childhood, and given medication, were more likely to report that meth "makes them feel normal" and exerts a "calming" effect on them. An East Bay African American respondent long ago found meth to be "just what the doctor ordered" for smoothing out his "rough edges." Now in his early 40s, he states:

I'm naturally a hyper person. Sober, I'm hyper. Straight up, I'm a hyper person. It kinda brings me down, takes the hyperness out of me. It actually mellowed me out a bit. (88)

Another San Diego user, a caucasian female stated,

When I'm at work I'm hyper, meth or not. ...the meth probably tended to slow me down a little bit from my normal. (345)

3. Improving the Drudgery of Everyday Chores

A primary motivation for continued use was the reported ability of methamphetamine to alleviate the boredom of mundane work, to aid in completing routine tasks especially housework. One woman user from San Diego, admitted to living an isolated existence in general. Meth gave her renewed interest in doing tasks around the house often for 48 hours or more.

I stayed up and did my bills, got my paperwork done, got my coupons organized, started projects I had been procrastinating on like filling photo albums and doing baby books. Just getting caught up on laundry and housework. I never stopped! (343)

Others described meth as the vehicle which enabled them to maximize their abilities:

*I'd say for about three years. Entertaining all over the world, Las Vegas, I'm a drummer that's my trade in the music world, they were readily available so....**I took speed not to be in with the crowd, I took speed just because it made me play better, in my own mind it did.** After you got off, 2 or 3 o'clock in the morning, and the bars in Las Vegas never close, you're ampy, that's where the seconals came into play. The valiums. (444)*

4. Enhancing Social Activity and Bonding

Some respondents continued to see meth as an intensely social drug and desired the company of fellow users.

I liked to go dancing, be in society, to shoot pool, be out and around people and people watching itself, I did that with selected individuals or myself. I didn't like to go blatantly out and make new friends, no! I loved to get high and go dancing or shoot pool that were not into robbing or stealing any more, they were out of it by then. (293)

...I couldn't use these things as an artificial anything. It was recreation and should be used for recreational purposes only. They told me that everything was false about drugs and not to study with them, recreational only! So, I never relied on any drug to help me. I know with a hit I can't do it, without a hit of anything, I can do what I must. Drugs are for recreation only! (051)

Going out on the weekends, staying up two or three days. Hanging out cause I'm broke. I'd be out with friends and they are the one's purchasing and I'm using from them. Speed is a very social drug. Usually if you've got it, you share it. Some share more than others. Your case #75, she's a friend of mine and we go out and share together. (078)

A substantial proportion of "local" Hawaiians, as well as Latinos in San Diego reported that meth gave them the opportunity to hang out with your buddies, to bond with your social network, and to make inroads into gaining female attention.

> *Mostly drinking and cruising. Anything I was doing, really. If I was doing yard work, then I loved yard work! Mostly drinking. Hanging out and doing absolutely nothing! That was good enough. Getting high with the boys, being a part of the ritual. (468)*

5. Relationships

Evolutionary patterns of use were often affected by close relationships with a spouse or lover. One Honolulu respondent went from snorting to injecting meth because of his girlfriend.

> *Cause she was. I like to shoot drugs, I like the whole trip involved. I'm a needle freak. It's like coke, when I found out you could shoot it, who the hell would want to stick it up their nose? Who wants to waste 4 hours to smoke it? I like to wham it in. It's always intense. She does it so I do it. We both do a lot. (529)*

It was common for respondents to speak of transitioning into a stronger mode of use in order to help their lover or spouse control their use.

> *Well, because she started using too much and becoming friends with people that were I.V. users, which was basically the reason why I stopped using I.V.. Because the people around me were just ruining their lives on it. Real, real hard core tweakers. I had never been a hard core tweaker. ...Because I wanted to keep the relationship together I thought if I got into it with her, I could ease her out of it! I don't know! It just went. When you get on I.V. use, it becomes a total addiction. (008)*

6. Dumpster Diving and Other Adventures

Although almost all respondents report having engaged in some type of drug sales, caucasians in San Diego were also likely to engage in trade and barter, or to sell items obtained in dumpster diving.

> *This is when I really started making stuff. We started ripping off a lot of wood tools. Ripping off a lot of wood. We used to get whole pre-cut pieces of wood cabinets and bring them home and build them and trade them for drugs. That's how I got my drugs. basically. (208)*

This often most productive--and profitable--flea market economy was especially characteristic of younger users in East San Diego County communities:

> *It seemed like the people who would dumpster dive, one of their only outlets for their goods would be the swap meet. They would show up at the El Cajon swap meet which is more of a garage sale swap meet and they would put their wares out, mostly broken down parts and beat up goods. No price tags, everything subject to negotiation. I don't know what the currency of trade was but I could guess. There is a certain stereotype amongst them, they're usually kinda ratty looking, drive older, beat*

up vehicles, they have tarps and trucks to hide their treasure in. Sometimes, they are mobile labs. More often than not, it's just their treasure that they have accumulated thru dumpster diving. (205)

This activity is not limited to meth users in San Diego, or necessarily to younger respondents. A 41 year old woman in San Francisco talks about this as a common activity, which is both practical and fun.

I go out dumpstering, biking and dumpstering is great! Hang out. Revamp clothing, find old furniture, furnish my house. Everything in this living room came out of a dumpster! (014)

7. "Tweaker" Activities: The McGyver Effect and Basket Weaving

Following rapid escalation of use, many respondents began to intentionally isolate themselves from others for long periods of time. These "hermits" preferred to spend their "tweaking" alone in the privacy of their home, often fixated for hours on the same activity of "fixing", "tinkering" or "artistic craftwork:"

At first it was a matter of well, ..I want some way to heat this lightbulb up because I didn't want to use a lighter cause it turned everything black. I hated this black shit, ... so I, o.k. a little stove, or maybe the heating element of the coffee pot, and I would take this things apart and find out no, this doesn't work, so then you got a perfectly ruined coffee pot, you got this torn apart, that torn apart, you got friend around wondering "Hey what the Hell is this guy doing, that thing worked yesterday"?, Just uncontrolled energy thinking you can do anything or I can take this and turn it into that, I guess the McGyver effect. (laughs) (296)

For many, especially male users in San Diego, being able to tweak was an important part their meth use. Meth gives them license to tinker--with a goal, perhaps, but no deadline, as some respondents described:

..we do that on our cars! That's normal for anybody who is a methamphetamine addict. Whether it's fucking with your syringe kit or holding a screw in your hand, you want to twist it until it breaks. I always had a wood screw in my hand, I don't know how they got there but I always had a screw in my hand! ...they called me "screw." I always had one. Twirled it for hours!(430)

I had a three bedroom house, two kids, large yard and a dog to take care of. He encouraged me get into arts and crafts during the day. I got creative and had fun. I loved weaving baskets, I decorated baskets and really got into baskets. That took up my time for a while. (229)

Another user explained why he had trouble with completing tasks while on a meth binge.

Yeah, I get too much stuff going. ...My current project is, I can't really say exactly. Mostly electronics...I can't really pinpoint it, whatever is available. What needs to be done. I'd say because of the speed. The irregular hours and stuff. I heard someone say "On speed, you'll do anything to get out of work!" It's true! You'll find yourself getting into things at home and before you know it, it's 9:00 or 10:00 in the a.m. and you obviously haven't gone to work!...It flies by! There is no concept! It could be 3:00 a.m., it could be when ever! (236)

Often, it is described as too much energy and too little focus:

> *I got all kinds of energy, but it was going nowhere. ... it was like I couldn't finish anything. I'd start a little of this, go to that, I'm moving real fast but I was getting nothing done, so it was interfering with my work. (296)*

> *If you're not smart when you start doing speed, by the time you stop doing it you might be! Because it will make you interested in something. Usually, a vast amount of things. Speed freaks were a busy bunch! (059)*

Being a busy person while high on meth, according to this same respondent, had a twisted paradoxical effect.

> *You get more done, ...but, speed is a real funny name for the drug! The longer you do it, the slower you get! ...It's like watching the wheels of a car spinning so fast it starts to turn backwards--or stand still. That's what speed does.(059)*

8. Sex Experiences

Perhaps more than in any other realm, the effect of meth on sexuality underscores the diversity of our respondents and the significant roles played by drug, set and setting in shaping user expectations and experiences. Many respondents (particularly gay males) in each site alluded to heightened and prolonged sexual activity resulting from meth-related stimulation and disinhibitation. A 30 year-old S.F. East Bay woman described never leaving her bedroom during a two week marathon with her partner:

> *It was nice! I had no idea it was two weeks! It was a lot of sex, listen to the stereo, more sex, do dope, talk, have more sex, for two weeks... I didn't realize it was two weeks! I coulda went for more! My kids missed me! Days turned into nights and nights turned into days! (070)*

For a gay male respondent from San Francisco, meth was directly tied into releasing sexual inhibitions:

> *Because my personality is that of a very repressed, white, middle class boy from the South. So, in order to be what I was, I had to stop all the inhibition from being raised so tight. [Drugs] allowed me to be sexual, to feel good, to not feel inferior, ...to escape from this very critical, judgmental, white, middle class background. ...Speed has always been very sexual for me. I was into being anally passive, that was my preferred role. They intensified the, extended the length of encounters. The orgasms were very intense. [And] they created the incredible desire to get fucked. I don't really understand why that is, speed is very anal. It makes you very aware of that part of your body. I wasn't into oral sex at all. (052)*

Often the rush was experienced as dramatically enhanced sexual pleasure. According to a San Diego user, for example:

No drug on the market has a rush that lasts long. ...that initial rush that you go after, that throat cough and the sexual drive high, that's what I go after. When I slam meth, I go off to that sexual drive high. ... It increases your euphoria in your head, your mind comes, that's one of the main reasons I like to do it! (324)

It was also common for respondents to report that meth expanded the duration and intensity of sex:

It allowed me to keep up with the men that was on it! [laughs] Yeah, if you're not as awake as they are, they can go for hours and there ain't no way you can keep up! If you're cranked up too, you keep up. It makes sex intense! You can shut out everything else and you're really into the sex. (070)

Other respondents believed that methamphetamine use largely eliminated or impeded sexual desire, and many complained of pharmacological inhibition of orgasm and erectile difficulties.

I can't get an erection up now. If I do, I have premature ejaculation. ... No, the desire is high. I want it but I can't have it. Having sex when I'm high is the best. When I'm not high it's the worst. There is some affect there from the speed. In the beginning it's more sensual, there's more feeling. It improves it. later on, the more you use, the drug seems to be less sexy. There's less feeling. I like a lot of foreplay, like hours of it. Speed enhances that wanting to touch and be touched. (093)

Controlling by modes of use, Estep and Macdonald (1993) found that injectors were most likely to have these difficulties among respondents in our sample.

...it was sexual, too. Later on, not at first. But I could function better on it, when I first did it. But with this stuff, I can't do that. Glass, I mean. ... The only time I ever did anything like that was the stuff that I got back in 1985. I did it and it went straight to my dick. For three hours I jacked off! I didn't intend on that, I just planned on doing some and going to visit a friend! I couldn't even fucking leave the room! (073)

For several respondents, especially women, there was an admission that enhanced sexual activity and even pleasure came at a price. As one woman stated:

There was no love, just lust I would think. Mainly I'd use crystal so I would have sex. The next day I wouldn't feel very good. (292)

G. Extrinsic Factors: Influence on Use Patterns and Control

Methamphetamine use over time was also influenced by external circumstances. The path of one's experience with the drug often depended on factors beyond it's desired affects, or the motivation of the user. Our findings reveal the most salient extrinsic factors having an impact on use patterns were issues involving availability, quality of the drug, and the influence of close relationships.

1. Disposable Income and Availability

Although many users described the price of methamphetamine as a major problem, it rarely led to a significant reduction in use. Often users who experienced rapid escalation of use turned increasingly to live within meth using subcultures where all facets of life were dedicated to obtaining and using meth. For those with straight jobs, it meant the loss of disposable income. For others, any means of income was legitimate, because it furthered the primary goal of obtaining meth. As one gay user explains:

> *I started out sharing flats with other gay people into speed. It generally turned out to be disastrous! ...Because they spend the money on drugs and not the rent! Everything becomes fucking unglued! [laughs] Slowly you get sucked into this sub-culture of gay people who are involved in speed. That's their prime motivation. Speed becomes the reason for everything. ...hustling, conning, shamming, stealing or something. Very few are still maintaining jobs. They have something going for them, they have to finance their speed use somehow. I got involved with the sex industry via telephone. We got into nation wide conference lines, we recorded and taped and wrote 2500 two and a half minute gay sexual fantasies. You can imagine how boring that was! There's lots of money in the sex business and pornography in particular. You learn early on that if you got the drugs, you got the power! People look you up, if they know you get good drugs, they find you! They want you to cop for them or trade them for something. If I'm not doing speed, I'm thinking about doing speed. (052)*

When asked what type of work fits into a lifestyle focussed on speed, he replied:

> *None, but, you make them! You work in dirty book stores, the sex business as a prostitute or phone routines. You learn to steal, you work the welfare system any way you can! (052)*

A number of respondents had served time in jails or prisons. While they were usually able to maintain a source of supply, there were substantial shifts in availability. One "enforcer" from the mainland changed his mode of use while serving time in prison, after he was able to obtain a rig from a biker connection and his girlfriend.

> *She introduced me to these guys, ...they liked me, ...I am sure in bike clubs methamphetamine is plentiful. They're sniffing and I'm sniffing, they didn't really like the needle, I get the stuff and go, that's the way you get high in the joint. That's where I started, cause of the availability. Sniffing is wasted. You can take that same and put it in the rig and get off good. (108)*

2. Perceived Quality Concerns

Users in all sites reported modifying their use based on the quality of the drug. When high quality methamphetamine was available, some users spoke of maximizing the opportunity:

> *I kept waiting for some good speed to come around. I'd try some every now and then and it was always shit. I went on a seven or eight day run cause the speed was so good. Two and three times a day, four or five times a day. Supposedly the speed is coming from the same place, it's supposed to be the same bag, but I think it's different. Sometimes I tweak between hits and when I do more, it really is much different. Some is much mellower. I can't understand that cause it's all supposed to be from the same bag. (093)*

When asked if he saw significant changes in the quality of the crystal in San Diego in recent years, an experienced user replied:

> *Once the chemical companies weren't allowed to put out ether anymore, the quality went way down. What they're using now is battery acid, rocket fuel. ...They take battery acid and use it to cook crystal. ...I never could quite figure it out. I think they're using it for a base. A lot of baby laxatives are cuts. Anything that they could put in with it. Get the cut from the head shop and grind it up real fine. Then it mixes in and you can't see it. The quality has definitely gone downhill. (289)*

Even though he was a regular and heavy user, there were times when these quality concerns caused radical changes in his use patterns.

> *...once in a while I just get fed up with the whole thing and I quit for a couple weeks. But never for any long period of time. After I quit and I'd start using again, I needed more than when I had stopped before. So, I just kept using. (289)*

H. Folklore and Beliefs

1. Beliefs on Modal Benefits and Dangers

Our data revealed surprisingly entrenched beliefs on both sides as to which method provides the best high, least toxicity and lowest potential for abuse. We also found a surprising number of mainland IV users who have come to prefer smoking as their route of administration An African American in his mid-40s who, not liking the burn and the fiending he saw with snorters, found smoking "provided a much more mellow high than snorting it." He also stated:

> *Something I noticed between a smoker and a snorter, a smoker takes it and enjoys it. A snorter abuses it and they get greedy. They'll tell you it wasn't good but they want more! ... [Smoking] there is no great craving for it. I can smoke and trip for a day. Once I come down, I eat at the time while I'm high. I can sleep when I use it if I eat. They're doing too much in their system, the snorters get greedy! Their mind becomes conniving, they want more. (088)*

The wide range of beliefs concerning both positive and negative aspects about different modes of use is seen in the following examples:

> *I don't like needles. Smoking is enough. Snorting gives me the drain or drip and I get off on that. The burn I can do without. But, I have to have that drip into my nasal passages. (266)*

> *Injecting any drug sounds so hard-core to me, like a junkie stereotype. I never considered slamming meth, nobody around me was. If they had been, maybe I would have, I don't know. I don't ever recall smoking meth. Maybe on a cigarette. I took it in my coffee a lot. ... I liked to snort it better, I liked the choke and burn! I liked playing with it. Drinking it, I couldn't tell when it would come on, I never knew if I did enough. (311)*

...smoking speed has got to be one of the most detrimental things you could do to your body! It's corrosive to the lungs and there is nothing worse than smoking speed. As far as using any drug, any way, it's the worst way, I would never even try it once!! It's absolutely ridiculous! I wouldn't. I tell people that but they don't listen. (293)

Smoking crystal seems to take me from a state of mind where I could handle it to where I couldn't! I was out of control completely! ...I was a crazy type person when I smoked crystal! Maybe 4 or 5 times when I smoked it,...a few hits off of a pipe and it made me stupid! I was chasing my tail, going in circles, trying to find something! ..when I came off it, I didn't know what I'd done. (326)

A sharp difference of opinion centered on the acceptability and dangers posed by intravenous routes of use. This was particularly strong among respondents involved with biker organizations who have had a traditional rule against IV meth use. However, as one woman stated, this has been broken increasingly:

I mean, if you're caught using intravenous drugs you're shamed. You're shown, 'This don't happen.' They don't believe in it. They make it, they sell it, they snort it, they pop beanies and drink Jack Daniels, but don't ever shoot any drugs. That's just something you don't do. (092)

Other respondents, including those without ties to biker clubs, described their conversion to injection by noting its euphoriant advantages. Many also believed it to be less harmful than snorting or smoking:

It's the safest way to do it, you are not damaging your mucous membranes, you're not damaging your lungs and it's going right to the blood stream. It seems to me the cleanest way to do it. (081)

Another respondent also thought shooting was much cleaner than snorting:

By not ruining your sinus and if done right, you're doing things cleanlier if you're doing it right. Throwing the stuff down on a dirty mirror and taking a dirty dollar bill doesn't make for sterile circumstances! (125)

After experimenting with every mode of use, this long-time user believed injection to be the least harmful.

When you smoke it, it goes straight to your brain. When you shoot it, it goes heart, lungs, brain. When you snort it, it goes lungs brain, it has to go down thru the stomach and into the kidneys and liver, then up to the brain. The different highs are vastly different, but, it's hard to define them. [Swallowing], not always but after a time, it starts to eat the stomach lining away. it's not real good for you. Physically, the best way to do it is to snort it or shoot it. Smoking it can be real bad on your lungs, it's a proven carcinogen. (059)

Other users believed that snorting bad quality meth would result in serious physical problems. According to one user, smoking was the only method that burned away the impurities. He gave this example:

It was a light yellow, break it down to the center it was a dark yellow but it would whiten up or lighten up as soon as the air started hitting it. Every once in a while they would bring some of that brown stuff. and they said that was the reason they started smoking it originally, because the brown shit, you snort it and it gives you sores and that, but if you smoke it, it doesn't bother you and you get a killer high.(296)

2. Beliefs About Types and Quality of Mainland Meth

"Crank" is described by our respondents as being most often a powder (although sometimes sticky) which may be off-white, have a yellow tint, or be light brown in color; sometimes combining those features in a way which slightly resembles peanut butter, hence the slang term. A woman from San Francisco's Mission district, compared this to "sparkle":

It's much more white, if you look at it its got tiny, separate crystals. Peanut butter is not crystalline and its gloppy, there's chunks in it, yellowish... I was up for a couple of days on peanut butter; you look hard on it and you grit your jaw. (059)

P2P methamphetamine tends to cause greater peripheral nervous system responses in addition to central nervous system effects, which many respondents say creates a more jittery, nervous feeling (along with higher blood-pressure) when compared with d-methamphetamine. Nevertheless this is the "high" preferred by some of our veteran respondents. For them, being high on "prope-dope" exemplifies the term "wired." A woman living in the S.F. East Bay said:

... the prope will get you straight up wired ... wired for days, walking around, I like to be wired until the point where I say, 'I don't want to be wired'. (105)

In contrast, many compare P2P negatively to the ephedra-based "sparkle," as does this Asian/Anglo woman dealer from San Francisco:

I call it (P2P) 'Speed from Hell,' crank is biker's speed, lower quality, its not as clean ... its hard on your body, you feel hot and icky and sweaty, filthier, and you don't crash well, and you get anxious. (014)

The ephedrine form of the drug is perceived by many of our users to produce a cleaner and stronger high, without the jitters associated with "prope-dope." Nevertheless some of our hardcore P2P user respondents miss the "rush" which is felt to be more intense, particularly with IV use. Because of this, some dealers resort to adding epsom salts or other adulterants for their IV customers who tend to assume that the less "wiry" ephedra type is a poor quality product. As with this respondent/dealer who said:

... we'd step on it ...we'd use epsom salts for the rush when they'd shoot-up ... sometimes we'd sell straight epsom just to give 'em a rush, and the guy would come back and say, 'Wow, that was good, it make my balls on fire. (108)

A woman who was long associated with manufacturers said that their product came out looking like sheets of glass. They then put the crystals through a grinder to turn them into the more saleable powder - the rocky crystals are hard for snorters to use, and some shooters are skeptical about rocks. She described their final product as having little crystalline flakes throughout, the archetypical look of "sparkle."

... you're going to have crystals that grow ... those large crystals, usually we grind those down and have what you call sparkle. ... We take the large crystals...and grind them down to a powder, if we didn't we'd call it glass, we've taken the product that we usually grind and marketed as glass. (095)

3. Folklore on the Importance of Taste

Descriptions of taste emerge throughout respondent accounts and cover a wide range of issues across all sites. When asked to compare crystal meth with ice, several respondents zoomed right in on the taste.

Ice is better tasting. They don't have like with crystal meth you have a meth taste, ice you don't. ...Sweet and sour, it comes in bubble gum taste, you have all kinds of tastes, man, some don't have taste, some do.(485)

He thought that crystal meth, however, lived up to its nickname.

Jet fuel. All I know is they call it jet fuel. I got a meth taste, it's sorry. It gives you - sometimes - after you light it for so many times, it tastes funny and it gives you a shitty taste and a shitty feeling. Kinda like bring you down. (485)

Another respondent relied on taste to distinguish between different types of ice:

One I really hated was the one with the meth taste. They called it "The Yellow Man". I remember the first time I picked up an 8 ball to sell and I tried it myself, I just gagged on it. It was horrible. Very strong and it has a very bitter taste and I said "Phew on this" and I went back to the guy and I had a big argument with him about that, cause he didn't want to give me my money back. And I said "Well I'm not going to sell my customers this" cause everyone was used to the good stuff, the clear, tasteless ice. (545)

One user who smoked meth with a lightbulb described his preference, in part, to the ability to gauge the quality of the product from the taste.

I could regulate it, you know, you could do a line and you're on the train, you're gonna go as fast and as far as the train is going to take you, depending on the quality but when you smoked it, you knew right away, when you took a hit that if it was good, that the taste and the effect in your mouth told you, o.k. back down, set it down for a minute and see what happens. (296)

Despite his preference for typically reliable "sparkle," a gay San Francisco user described what he learned to accept in his 16 years of shooting meth:

You gotta go with whatever is the flow! [laughs] Whatever they are letting be on the road... Pink champagne, prope-dope, gardenia. [What is gardenia like?] It's a heavy heat-rush and it's got this funky aspect and it's like flavor and taste and scent of a gardenia. I can't stand it! (003)

Another stated a similar opinion.

Um, it leaves a bad taste in your mouth. This meth I'm using right now leaves a bad taste in my mouth the next day. I was selling an MDA-kind of drug and it left a weird taste in my mouth like this speed I'm doing. Like phlegm or mucus that was weird. (093)

According to one user the ideal smoking meth was the poor quality product adulterated with battery acid.

Actually the one I liked the most was the, when you put it in there it had like a battery acid taste and that was the type when I first started. You'd hit it and it was like that battery acid or something, your teeth, gums everything in your mouth felt like it was just going to rot out and drop, and that's, you take a little hit and go "OHH, o.k. that's enough. (296)

4. Folklore: Hawaiian "Ice" vs. Mainland "Glass"

Most of our longtime mainland users remained skeptical of the mythical "Ice" which had yet to appear in their presence. Many of those that had seen alleged "Ice" or listened to descriptions provided by respected colleagues, increasingly decided that it was actually a form of the highly praised mainland "glass":

Several respondents in our California sites assert that they make Ice using a "Rock-Candy" recipe by carefully warming high quality methamphetamine powder with water, super saturating it in a pyrex pie-dish and when it cools, viola: Ice. Manufacturers and some knowledgeable users on the mainland emphasize that the same effects are felt from sparkle as from glass or ice, it just looks different. The respondents quoted below echo the same conclusions drawn by others in the trade: ice from the Philippines and glass from the mainland are basically the same product. A 39 year-old man, who was a cook of the ephedra process in the San Diego area described his way of checking for purity, sounding exactly like ice as it melts and recrystallizes:

... they say they take what we do and they clean it up. I can't see how they make it any cleaner than we do. ... There is a process where they can take what I make and they can turn that back into glass. I've seen them do it. Just chopping it up in real fine piles and spraying purified water on it and cooking it off like that. It turns it into the prettiest glass I ever see ... if its clean, its gonna burn clean, that's how I tell the purity. (227)

Respondents in mainland sites often had solid ideas about ice, both positive and negative, regardless of their naivete. When asked about her knowledge of ice, one San Francisco woman replied with negative vigor.

Only what I've read. I don't want to experience it. What I've read and from some people I know who have done it, they told me it ain't nothing nice! I listen! If they say it ain't nice, I take your word for it! I don't want to mess with it. I've read that some people have tried it and it's killed them. [Have you seen any?] Never. People that have done it said it was NOT a good trip. (088)

Another woman from San Francisco had a strikingly opposite view. She describes ice from the point of view of a mainland user and dealer who does not know any Hawaiian users:

The rush is wonderful! You don't spend five hours looking in your closet for something that's not there. You're not destroying your telephone. People that see it are just astounded. It looks so great. No one has seen stuff like this before. Everyone has heard about it but nobody has really seen it. I saw it. ...The person I get it from went there [the Far East] himself. That's where he experienced it first. I know he's telling me the truth about it. I thought there was no such thing but, this is so fresh and so strong, you'd think it was made here ...It's not wet, it's very dry. He gets it from the Philippines. It's incredibly expensive, it costs a lot. Once people see it, they want it. They know it's worth the price. ... He calls it ice or LA Glass. I call it "Quartz Crystals." (014)

However, several mainland users voiced opinions similar to this woman dealer from San Francisco, who said:

... I don't think there is anything separate called Ice. I think it's a total affectation of the media, I don't think there is any difference between glass and ice ... (095)

A late twenties white male was unusual in that, although living the mainland, he always smoked his methamphetamine. He started manufacturing to insure he could get a high quality product in the San Diego area and when asked what he knew about ice he said:

I know that meth can be made into ice ... glass, 'cause I've done it. I take it in the powder form and mix it with denatured alcohol. Put it in the microwave for a few seconds, take it out and it dries clear. If it's dirty, you have to wash it in acetone to get all the impurities out of it. It looks like ice when you chop it up, you can see the crystals. (271)

Respondents in Honolulu voiced a variety of comparative assessments. When asked about his first ice use, this Samoan first noted the similarities and differences between ice and methamphetamine. When asked why they call it different names, he replied:

I have no idea, it's the same, except for the taste. Crystal methamphetamine has a harsh taste, cause meth comes in powders. It goes down smooth but after you blow out it doesn't make you feel too hot. Just like smoking a joint, the harsh. You got to suffer in order to get that high... Ice comes in rocks. You can tell it's ice cause it has a cherry kind of taste. That's the real one, it's hard to come along. The first time I tried it, I fell in love with it cause it tasted so good. My friends thought I was crazy. (503)

4. Beliefs about Quality: Water-Based vs Oil-Based Ice

Respondents seem to have a clear preference for one or the other, often using identical but conflicting rationales. For some users the country of origin is attributed to "types" of ice: water-based and oil-based. No definitive chemical basis is apparent for this "street" topology, and there is considerable disagreement over the characteristics of "water" and "oil" base. Opinion is divided over which is better depending on whether it is Korean Ice, Filipino Ice. When asked if Korean Ice was oil based or water based, one experienced distributor stated:

That part I don't know. It's just a different way of making it. The Korean stuff is heavy, so you only get a little bit, but the fucker is strong! It evens out. I've seen purple stuff! (521)

One of our more informative Oahu respondents, a Filipino/Hawaiian man of thirty eight who had been a heavy dealer had the following to say about ice and its origins:

> ... *ice comes from the Philippine Islands and the mainland, the mainland produces their own now, they have the formula. ... If you get the clear, clear one, if the bag is wet, then you know it's oil. That's coming from like the Philippines. The yellow stuff come out of Korea." I go by the coloration. That's how you can tell good stuff ...clear or yellow. The clear, clear one, if the bag is wet, then you know it's oil. That's coming from somewhere like the Philippines. The yellow stuff comes out of Korea--Choke stuff. (429)*

In another example, a Filipino user and distributor stated:

> *Korean ice, it's not as clear, it's jagged. Philippine ice is cloudy and has a lot of colors in it, like yellow, it smokes better (523).*

A female respondent of mixed Chinese Asian ethnicity, who basically lived by doing favors and making deliveries for big-time dealers, the Korean Ice was yellow, and thus better:

> *Sometimes... it was water-based and it was not as good. Sometimes, it was oil-based. Sometimes it was from the Koreans and it was better! The water-based is very white. The oil-based is very yellow. So when it burns in the pipe, it comes into a beige/yellow instead of a clear white. ...Oil-based lasts longer. You don't get as amped, the high on it is a little mellower high. ...[The Korean's] was oil-based and it was stronger, it didn't have as chemical a taste to it (482).*

Although there seems to be general agreement that oil-based ice is better, the reasons fluctuate widely.

> *Oil base is good stuff. Water base, it evaporates like that! You can have a big puddle but, it's just gonna go up in smoke! I don't like water base. A lot of my friends get the good stuff. We buy oil base. It's good, sweet stuff. They even got this other one called meth. It's strong tasting and it's yellow. I like clean, fresh Ice. Sometimes you get the dry one but there's also the wet one. If I have a choice between the dry Ice and the wet Ice, I'd rather have the wet one! The dry one looks dull. The wet one looks clean and clear. I'd rather have the clean, wet one. Sometimes the wet one is the meth. The meth is not washed good. You got that strong taste and it's real yellow. When you cool it off, it takes a while to get hard (459).*

This street distinction needs more study, but one possible explanation could be that the "water" type is most likely cut with water, as is implied by the following comments by an ice smoker in Honolulu:

> *I always used to think it was water based till about 3 months ago. We used to add a couple drops of water to our pipes and almost bring it all back again for another couple more hits. That would have to be water based, to be able to do that! A couple months ago my girlfriend had some alcohol, 91 proof, she put some in her pipe and brought it back even more than it was, so hers must have been oil based. Yeah, there is and it brought it back even better than water ever did. I think oil based makes you get more. I don't know, to me, it seems stronger than when I first started doing it in 1988. I think that was water based then. Now, it's more oil based and it seems more potent. I'm really not sure. (549)*

Given the confusion over the exact properties and defining features of either type, respondent beliefs on how they effect the smoking experience vary considerably:

> *Water base is when they do the breakdown on it, when you put it in your pipe and you light it up before it starts smoking, it should turn into a little puddle. If it's a water based mixture, it's just gonna evaporate on you! If it's done with oils, it will sit and puddle on the bottom and stay there. It's about six times stronger. (546)*

> *I'm not sure how exactly, a lot of them are adding water to it. Someone told me they were putting oil on it. And make it weigh more but that's not true because you couldn't smoke it then! Cause it'd burn up. I think they're just adding water to it. There's really no way you can cut it unless you put salt in it. Half the time, I don't know what it is, I just do it. (530)*

There are several indications that some of this confusion was due to the diversification of the product on the market. Opinions differed on whether or not this was the same "ice" from the same sources, or if it was mixed with new product. According to one user, the "ice age" was a thing of the past.

> *I feel there's a whole lot of ice on the streets right now. It's just the quality. You have really bunk stuff. Some of the stuff is real watery, some of the stuff is really good. There's a lot of it, but there's such a difference in quality now. Before, it was either good stuff and now, it's just like any other drug that gets cut. Like cocaine. (530)*

I. Rules and Rituals: Maximum Benefits vs Minimum Harm

Older, more experienced users, especially, were able to cut down or stabilized their use over the years in an effort to maximize the benefits and minimize the problems. They described diverse strategies which employed with varying success.

1. Basic Rules Involving Use

One very long time female user in central San Francisco, has detailed rules governing her monthly high and her responsibility to her children. She described the following process which begins when she receives her monthly $688 welfare check.

> *When I buy speed at the beginning of the month, I buy me 1/16th. That's $150. I like to be high 3 days, I want to be high 3 days. If I'm high 3 days it's worth it. I don't feel like I'm cheating myself! Like being high one day and don't be high the next, that makes me hunt for it. If I'm high 3 days continuously then I'm satisfied. ...I pay my rent first. My rent is $260. ... I buy food and pay rent. Then I buy speed. But when I can't find any good speed. I smoke crack. (149)*

This ritual also involves clear rules governing her responsibility to her children.

> *Only thing, when I get high on the first, second and third of the month, I'm high three days. This was the understanding with my children, I'm high three days and don't bother me! [laughs] They don't. I cook and prepare food in the freezer. All they had to do was put it in the oven! I made sure they had money, I made sure I did everything I had to do for them.*

That was the understanding between me and them. We never lost that. ... I took care of my kids. Always, no matter what. Ain't no such thing as I'm high and I ain't gonna take care of my kids, never hungry! Clean clothes and combed hair. Those always be my kids, my responsibility. (149)

If it's a hassle to get it, I won't. ... I won't buy from just anybody! I call my few sources to get my speed. I don't want to be with other people when I get high. Not in a room full of strangers. Also, I wait until I get home to shoot up. ...I don't do anybody's hit. I get high with people I know and watch the amount I take. I never have felt out of control with my use. Because I have these rules, I don't even think about the rest. I've done it for a long time and know how to be safe and not get busted. I don't ever desperately need it! (027)

Another IV user operates under a system of rules which is short use episodes and small doses.

At one time, I've never done more than 2/10th of a gram, a 1/4 gram. Maybe. ...if the speed's any good, you don't need any for a day. I was trying to say the perfect speed is you get a good rush out of it, 20 hours later, you realize that you're high! ... I've never done [large amounts] and don't have any intention of doing it. I don't want to over amp! I get what I want from the drug, why do something different? (013)

Others set rules for times and/or places where use will not take place. For example, one man in Honolulu has a rule never to use on *"special occasions like when I get in touch with my family, I won't do 'em." (472)*

2. Rituals: Survival Tips from Long-Time Users

Respondents often described experiences and methods used to counteract potential dangers or to maintain their health. For example, a female respondent believed IV meth to be a good antidote for counteracting a potential overdose of heroin:

Yeah, it's like when you'd have it, if you'd do too much heroin and you OD on heroin, the first thing you think of is if you got speed on you is slam them with a hit, like a quarter-gram of speed... Or you can shoot them with salt water. Well, see, speed is salt soluble, anyway, and its main substance is a salt soluble. It's a salt. And salt water, it'll kick their adrenaline back in and make their heart go. And you slap them a couple times, you know? (092).

For another user, survival involved regular food and rest, even during heavy binges.

Yeah, my patterns were pretty heavy. I was doing 1/16th a day. I liked to do 1/4 in the morning, 1/2 gram in the afternoon and then 1/4 again before night time. Before morning, about 4:00, I'd lay down and rest. At least stop and think! I tried to eat a little bit all the time, especially drink some V8 juice and keep myself healthy enough to get high! That was very important to me, always has been. I understood and saw the affects of being able to stay a little healthy to get high still. I always utilized it as such. (293)

When asked if he was able to maintain his mental health, by keeping to a healthy nutritional and exercise pattern, this user replied:

Definitely! Without a doubt! I understand that the drug mentally causes chemical gases in your brain and blood to change if you've used it for so long. Your brain is so hot, or just a couple degrees warmer than it should be for a couple days and it makes you see things or hallucinate. If you keep a little food in your body and you keep your circulatory system strong, being able to use it again is easier. Being able to find a vein is easier. Eating and drinking a little bit helped a lot. (293)

3. Rituals: Minimizing the Crash

Users in all sites who were likely to regularly engage in lengthy runs which often lasted until total exhaustion of either the supply or the user developed various ways to deal with the crash. In many cases, this involved the use of another drug to aid in the come down. As one respondent explained:

Well, when I get too disgusted, I take a bunch of downers. I take Valiums. ...about four, five, or six. That will be just right. ... Sometimes a few drinks relaxes me too. The Valiums don't do it by themselves. Because ice is very strong. (535)

Many respondents described their preference for marijuana to help them come down from their meth high. One person now uses tranquilizers, talks about how he would rather have marijuana:

I used to use marijuana...before. But it's so hard to get weed now. If I had weed, I'd use it. But not as much as before though. (472)

A surprising finding, however, were the number of respondents who preferred to use nothing. This was aptly illustrated by a veteran San Francisco shooter who knew when his "run" had come to an end:

At a certain point of exhaustion, even a "big hit of speed" wouldn't keep me up. It would almost, like, end it all, knock me out. (001)

I don't use anything to comedown. I like to comedown off the drug naturally, otherwise if what you're using to comedown with, you'll probably continue using that thing! I don't want to get into that thing. (093)

J. Summary

The findings presented in this chapter are systematically analyzed portrayals of drug-using worlds rarely exposed to scientific analysis. The chapter charts the physical, emotional, structural and social pathways directing the diverse evolutionary patterns of methamphetamine use. The data reveal dynamic patterns, rituals and rules which act as cross-roads in strategic moments of a user's "drug career." The following chapter examines the relationship between these evolutionary journeys to a range of consequences and problems.

TABLE VI-1

OTHER DRUGS USED IN PAST SIX MONTHS: BY SITE
(Respondents with any lifetime use)

	SAN FRANCISCO	SAN DIEGO	HONOLULU	TOTAL
LCOHOL	(n=142)	(n=149)	(n=142)	(n=433)
never	19%	21%	25%	22%
1 - 60x	51%	44%	34%	43%
1 - 180x	29%	36%	41%	36%
ARIJUANA	(n=146)	(n=147)	(n=147)	(n=440)
never	27%	21%	33%	27%
1 - 60x	38%	26%	25%	31%
1 - 180	25%	49%	42%	42%
OWDER COCAINE	(n=140)	(n=145)	(n=133)	(n=418)
never	61%	70%	59%	64%
1 - 60x	37%	28%	27%	31%
1 - 180x	2%	2%	14%	6%
RACK COCAINE	(n=106)	(n=83)	(n=111)	(n=300)
never	55%	72%	57%	60%
1 - 60x	41%	25%	30%	32%
1 - 180x	6%	2%	13%	8%
EROIN	(n=102)	(n=58)	(n=38)	(n=198)
never	41%	74%	76%	59%
1 - 60x	36%	22%	21%	29%
1 - 180x	19%	3%	3%	12%
SYCHEDELICS	(n=130)	(n=127)	(n=84)	(n=341)
never	79%	78%	86%	80%
1 - 60x	22%	22%	13%	20%
1 - 180x	0%	0%	0%	0%
RANQUILIZERS	(n=106)	(n=97)	(n=65)	(n=268)
never	45%	61%	63%	55%
1 - 60x	42%	32%	34%	36%
1 - 180x	13%	7%	3%	9%

TABLE VI-2

DAYS WITHOUT SLEEP PER EPISODE: BY SITE AND GENDER (in percents)*

	SAN FRANCISCO (N=150)	SAN DIEGO (N=150)	HONOLULU (N=149)	TOTAL (N=449)
0 Days	3%	9%	1%	5%
1-2 Days	33%	38%	37%	36%
3-4 Days	45%	40%	35%	40%
5-6 Days	9%	7%	9%	8%
7 + Days	10%	7%	17%	11%

* PERCENTS MAY NOT ADD UP TO 100 DUE TO ROUNDING

CHAPTER VII.

CONSEQUENCES AND EFFECTS OF USE.

A. Introduction

Regardless of the trajectory, career paths of methamphetamine users almost always led to a number of serious consequences. Eventually, for many respondents, the harms associated with use outweighed the benefits. In this chapter we present findings which examine those consequences which include physical, behavioral, psychological, and social effects. This is followed by a discussion of findings on methamphetamine's harmful consequences to the entire communities in some areas.

B. Physical Health Consequences From Heavy Use

Heavy and prolonged use of methamphetamine resulted in several adverse physical consequences according to respondents. The most immediate of these was the "crash." This period of recovery after a prolonged binge could be quite painful, often involving a variety of problems. Over time many of these physical consequences cease to be episodic and become chronic, with serious and long-term effects.

1. The Crash and the Post Crystal Syndrome

There seemed to be a direct relationship between heavy binging patterns and extensive negative experiences with coming down after prolonged use ranging from several days to several weeks of a single binge with methamphetamine. A representative and very articulate description of after-effects was provided by a respondent in San Diego who referred to it as the *"Post Crystal Syndrome," or PCS.* This come-down effect particular to heavy and lengthy binges may last a week or longer. Commonly known in San Diego, this condition is eloquently illustrated by one respondent:

> *There's a certain pattern,...your first day off you're okay because the stuff is still kicking in your system so you don't feel the high that you did but you don't feel the down that you're going to. On the second day, you become a zombie, some Haitian voodoo doctor's idea of a good human being! ... you're a eating and sleeping machine! You get what we call the "waking nods!" Third day is even worse, it's the absolute coma. The only time that you wake up are the times you want to eat! Fourth day, same thing! It's kind of a mimic of the second day, you're a zombie... You have no motivation, you don't have a terrible desire to do the drug because you know it won't work on you! Fifth day, you start to wake up. ...you get a glimmer of your real self back and that's the time you start again! Go back out and find some and you do it and boom, you're right back up to where you were. (205)*

2. Weight Loss

Although dieting was a motivation for the initial use of methamphetamine among many users, weight loss was also an unintended consequence for others who had different initial motivations when they began using methamphetamine. Over two thirds of respondents reported weight loss as a major consequence of their methamphetamine use. However, as Table VII-1 shows there were significant

differences across sites and by gender. Although a higher proportion of women overall reported this as a major consequence (72 percent compared to 67 percent for men), there were notable differences across sites. For example, 89 percent of women users in Honolulu, compared to 69 percent in San Diego and only 57 percent in San Francisco reported that their meth use resulted in weight loss. Similar, although less dramatic effects were found among men in each site with 75 percent of males in Honolulu, compared to 74 percent in San Diego and only 51 percent in San Francisco reporting weight loss due to their meth use.

> *No, I would go days without eating. I started to lose a lot of weight, and it was noticeable. People started questioning me and that's how certain people found out that I was using and it was like we would have never guessed. ... So, I kept to myself a lot. I lost a lot of weight. I did. (249)*

> *I didn't eat for two months, nothing, when I was on the streets. I weighed 175 to 135 in a month, between one month and two months. I went into Denny's to eat and I couldn't even eat. The food made me throw up! I couldn't hold nothing down. (002)*

> *At first, I started losing weight and thought that was great! I thought I felt good. Towards the end of it, I got circles under my eyes and sunken cheeks and looked like a skeleton. My physical appearance was that I looked sick! People were noticing and made comments. ...You could see all the bones in my shoulders and rib cage, it was sickening. ...I wore lots of clothes and covered up how thin I was. (469)*

3. Skin and Teeth

A common characteristic of heavy and prolonged methamphetamine use was the deteriorating condition of the user's skin and teeth. Our respondents described various manifestations of these physical afflictions:

> *These speed people look hideous! ... I don't think anybody, after years of speed use, it takes a heavy toll on your looks! Especially the teeth, you know? Lots of people in this town have these horrible teeth! (017)*

> *I'd get up in the morning and saw my skin get really shitty. Really bad. My face would break out really bad and some people I hung with had open sores! (469)*

> *This last time, I have a skin infection, staph infection. As you can see, last time I did speed it was really good and I did 1/16 in two nights and I get allergic reactions sometimes. If the speed is really powerful, it's like liquid drano and it just really messed up my skin. (002)*

Some respondents believe these problems were due to different forms of toxic reactions. For example, one user stated:

> *I had phenylacetic poisoning in my hands. My hands swelled up so bad they were like white worms were sweating out of my skin pores. I went to the doctor. ...He knew exactly what it was. He said, '...you've got to cut down on that,'...it can be fatal, you can over-amp yourself.' The phenylacetic poisoning itself, he said wasn't fatal. (108)*

4. Heart and Lung Problems

Several respondents reported that their meth use led to, or exacerbated, serious heart and lung problems.

> *This December I had a mild heart attack. I was in the hospital for a while. ... It's from having endocarditis and weakening my heart and not taking care of it. I'm always sick. Even if I eat healthy. I take vitamins. I still get sick. (066)*

For other respondents, escalating meth use led to a deterioration of their lives to the point where these problems were an inevitable result.

> *I'd catch a simple cold and I'd keep smoking the drug and it created more of a problem in my chest. It got to the point of having bronchitis. I couldn't breathe or walk, it felt like my lungs were going to collapse! I'd wind up in the hospital and they'd put me on a machine to drain out my blood, they poured a lot of liquids in my blood... I'd stay in the hospital with a lot of chest pains. (495)*

Users also reported chest pains and shortness of breath, often believing they were having mild heart attacks due to their meth use. One woman stated:

> *Once in a while...I start sweating a lot and I think I have mild heart attacks. When I take a shower, I'll sweat for about a half hour. My heart races like I have to sit down and catch my breath. (449)*

5. Hepatitis

Hepatitis was a serious consequence, especially among IV drug users. One respondent who claims to have had hepatitis twice in different forms describes the experience:

> *When I was on the streets. I didn't know I had it. I was really sick. My boyfriend and me went down to the hospital. We were living in a trailer with no lights and stuff. Taking showers at friends houses and stuff, I couldn't move. I couldn't eat, I couldn't hold nothing down. Then the second time I had it was right before we couldn't pay the rent. ...I was really sick again. I had non-A, non-B but C... It was kinda hard to understand. I was in the hospital with it, this last time. I was so dehydrated cause I was using major drugs. ...That's when I got hepatitis again. I went in the hospital, I was really sick. Not only from hepatitis but from doing so many drugs. I lost a lot of weight and I was just sick. They were surprised I was still alive, I guess! (002)*

6. Other Physical Problems

A San Francisco user who has used both speed and heroin for many years explains why she has had to reduce her meth consumption:

> *I have a perforated ulcer now. I was just diagnosed as possibly having diabetes. ..I'm 46 years old. Heroin treats me better. My stomach is easier on it. I don't have internal bleeding like I do on speed. ...If I do too much. If it's good speed, it doesn't take very much to get off.*

If I do too much speed, no matter how good, I'll start hemorrhaging from the rectum. Plus, I get unstoppable nosebleeds for hours on speed. I know I'm no spring chicken anymore. Heroin doesn't do that to me. (029)

Another physical illness reported among our meth users was diabetes. Often it is a pre-existing condition, and at other times it may be aggravated by their meth use. One man who was diagnosed with diabetes at 13 years of age mentioned a range of physical ailments including diabetic seizures in connection with his use of meth.

I get welts on my body from the crank and I have an ulcer that sometimes bleeds. I take away the pain with heroin a lot of times. I think I got the ulcer from crank use. I snorted crank more than I ate it, but I ate crank a lot. And I have diabetes. Which I often have problems from the crank over, I have seizures and stuff. I've had brain damage from being revived so much. From the seizures. ... It stems from the fact that when I have an insulin reaction, I don't know when it's happening, I'll just think I'm too high. I'll walk around and not know where I am or what I'm doing. I start to sweat or my legs start to itch, little bits of my brain are warning me and I've damaged that part of my brain. It's called Brittle diabetes now, but it wasn't that in the beginning. (094)

Several respondents also reported epileptic seizures, which occurred especially after periods of heavy use. Although he could not establish it, one respondent linked this to combinations of drugs used with meth.

I think people have seizures because they get high and take pills to come down, and their body can't stand the shock! ... I'd have a seizure, I didn't know about it. When I came out of it, I still didn't know nobody. It would take me a couple of days to find out who everybody was! And why they was looking at me so crazy! I didn't know anybody for several days! (049)

C. Individual Effects and Consequences

1. Addiction and Control

One important finding to emerge from this study concerned beliefs and attitudes on issues of addiction and loss of control. More specifically, this research data revealed divergent and specific identities for the concepts of "control" and "addiction" among our respondents. As seen in Table VII-2, although 60 percent of our sample reported "ever" feeling addicted to methamphetamine, only 48 percent stated they had lost control over their use. This discrepancy was more pronounced among women users. In general, women were more likely to report feeling addicted to their use of meth than men (63 percent compared to 60 percent). However, they were **less** likely to report loosing control over their use (45 percent) than men (50 percent). The major exception are Honolulu male respondents with a slightly greater percentage reporting addiction to meth (58 percent) than loss of control over their use of the drug (57 percent). Analysis from the qualitative data suggests a significant number of our respondents considered themselves to be "controlled addicts" which were based on definitions particular to the specific context of their drug experience.

Addiction: Respondents often talked about addiction as if it were a normal consequence. However, there were several different interpretations which defined the basis of their addiction. For example one respondent defined this addiction in physical terms:

> *I'm addicted to speed. If I don't have it, it takes me weeks to get normal. Right now, I haven't done any in two days. It took me until 2 o'clock, it's a good thing you set this interview up about 4 o'clock or I wouldn't have made it. ...You don't realize it during that time, your adrenalin glands and other stuff, they ain't working. They don't need to. They don't need to! When that stops, it's not like these physical functions have been shut down during all that time and it's gonna pick up the slack right away. It ain't gonna happen. Doesn't happen. (001)*

A Honolulu user believed her addiction was based on psychological craving:

> *It's so psychological. You don't really need that much ice but you always want more. You want to chase it. It makes you want more. (481)*

Another woman from San Diego states:

> *The trick with that drug is, you're not using it, it's using you! It won't let you remember to do things. It won't tell you to eat, certainly not! But that's the name of the meth game, abuse.* ***It leads you right down the aisle and up to the alter of abuse.*** *It always takes some more. Your tolerance level is always building. (286)*

Control: Respondents had very strong feelings about being either in control, or out of control over their use. In general, women were described, by both genders, to be more likely to have control over their use and of their lives while using meth. A woman in Honolulu feels men tend to loose control much easier than women:

> *Sometimes they get like that because of being high. They do things that they really normally wouldn't do. It can get your mind screwed up. It's a good high, but you gotta know how to handle it. A lot of my friends say* ***it's strong enough for a man, but it's made for a woman!*** *A lot of guys get really crazy. Even my boyfriend, he gets crazy off it. Real scary. I don't really want to smoke with him, cause he scares me. He thinks I'm hiding things! I get high all my life, nobody ever bummed my trip! That's bullshit.(459)*

Our findings suggest that there were gender differences in the way respondents **talked** about self control. Women were more likely to stress the ways they managed to stay in control. Men, on the other hand, were more likely to discuss ways they had lost control. They were far less likely than women to talk about how to manage to stay in control. For example, within a year of starting to use meth, this user found that he was unable to rationally control a meth habit which had rapidly escalated to a gram a day, everyday:

> *I woke up one morning saying I gotta get wired, and I, it just hit me, immediately after the thought, I didn't have to get wired last year to get up, and be normal, and I went in and looked in the mirror and saw one of those people, that I had seen under the dashboard, med students that are now mechanics. I was becoming that, and that's what stopped me. ...I mean that, crank was becoming a focal point, my life revolved around being able to get crank or procure it for somebody else, getting a little bit, to sell it, so I'd have some of my own, but, the focal*

point of my life shifted from taking care of the bills, to looking for crank, and I didn't even realize it, I didn't see the shift. Until that morning that I woke up telling myself that I had to get high. (081)

For other respondents their loss of control was tied into their mode of use or in combination with other drugs.

I was out of control the day that I tried it! I should never have tried it! From that I ended up freebasing coke for the 1st time, too. I was also mixing both of them. That's when I lost control of my life, when I smoked ice. (468)

For women users, on the other hand, the ability to maintain control was a very important issue:

I have this phobia of something controlling me! Don't get me wrong, this controls me but, I have some kind of hold on it and I refuse to give in. If I have been up two or three days and I feel like I'm getting detached, I don't want to let myself get to the point where it could get any further. You hear these horror stories all the time and I refuse to let myself get to that point. So, if there's any warning signs of any kind, I listen to them and I'll go lay down and go to sleep. If I need to eat then I'll eat. ...I don't want to hallucinate, I don't want to be in la-la land where I have no control over what I'm seeing... I know when I get these little signs that it's time to go to bed, then I don't let it over power me. I never let it come before my rent or food! Ever since I started doing it, I made money on it so I can have my own personal stash, without it coming out of money that is already spent. (297)

Another good example of a respondent claiming to be in control and addicted at the same time.

Some people can't handle it. Some people let it control them. They can't. There are people out there that can't handle it, and there are people--and I consider me one--that can control it. I know when I've had enough and when to stop. And I don't get out there and I'm not tweaked and spaced out. I'm not gonna say I haven't been tweaked and spaced out, 'cause I have. But I don't like getting to that point. So I make sure I stop before it gets to that point. (083)

Similar gender differences are found among male and female dealers discussed in chapter IX.

2. Memory Loss

Approximately half of all respondents reported some memory loss as a serious effect from their use of methamphetamine across all three study sites. In general there was little variation by site or by gender with one exception. As seen in Table VII-1 both male and female users in San Francisco were significantly less likely to report memory loss as a serious consequence of meth use. Only 40 percent of males and 34 percent of females stated this was a problem even though this group were the most long term users. The qualitative data reveal several interesting contexts. According to a Latino male in San Diego, for example:

Honestly, I can't remember a lot of things. Memory is mostly gone. I'm not gonna lie to you! My girlfriend will sit there and tell me things that happened 2 or 3 years ago and I can't remember. (248)

A male respondent from Honolulu stated that his difficulty remembering things is because meth, "messes up your time frame." For others, this problem has led to other consequences. A dealer from Honolulu states, for instance:

> *I had memory loss. Once I kept my stash in my son's room and once someone came over to pick up something, I was looking in my room! I couldn't find it and got all paranoid. When I finally found it, I knew I had put it there but I didn't apologize to anyone or nothing. (461)*

3. Depression: Loss of Self Esteem and Suicidal Tendencies

Findings in Table VII-1 also reveal a high proportion of users reporting serious depression as a consequence from use. Overall 67 percent of male and 70 percent of female respondents stated that meth use led to depression. There were differences across study sites with only 59 percent of males and 61 percent of females in San Francisco stating this was a problem. This was perceived as a problem by a much higher percentage of both sexes in San Diego and Honolulu. It was the greatest problem in San Diego with 70 percent of males and 82 percent of females reporting depression, and slightly less so in Honolulu with 70 percent of males and 60 percent of females reporting depression. For many who began using meth to enhance self-esteem, the loss of control and increasing dependency led to an eventual decrease in self-esteem.

> *Women especially, have very serious self esteem problems. Speed accentuates the deficit. You have to be comfortable inside your person. You're locked in this body for the duration. (095)*

Respondents attempting to use meth as an escape tool generally had little success:

> *Just because of my life, I did not want to do anything else, I hated myself. I didn't want to live anymore, I was stuffing all my feelings with drugs, wasn't working, going to school, I wasn't socializing, all I did was lock myself in my room and I couldn't put the pipe down. I couldn't do it by myself. (314)*

Another example concerns how loss of self-esteem serves to compound feelings of guilt:

> *The things I was doing, the guilt; and I couldn't look at myself in the mirror no more. Cause I didn't want to see myself, knowing the things that I had done to my family and to others. So, ice made me didn't give a shit about myself anymore. Or anybody else! (403)*

A male respondent in Honolulu describes similar feelings about how the loss of control over use led to depression and suicidal feelings:

> *Especially when that depression mode starts kicking in. ... It's mind over matter. You have to have a strong mind NOT to get out of hand. If you have a weak mind, you'll lose control or start to lose control. Something's gonna foul up! For me, I've a very weak mind but I like to think I have a strong mind. But, not so! I'm always fighting it. I'm always saying that I'm gonna seek help but I put it off cause I get more stuff and it looks good. After I smoke it, I forget what I was gonna do to get help. I'm back where I started from. ...I started losing it. I started losing my self-image and self-respect, my self-esteem, my pride. I started going down. (509)*

Another respondent adds:

> *That's why when I come off the drug I want to get away from everybody! Because I get so depressed! It seems like I kicked the ice back in October and all the way into November. I got back on the ice just before Christmas and the depression I feel now, cause I'm almost at the end of this rope here, is worse! I look for pills or anything, when you stop you can just end it! Your life gets so out of control. Everything is screwed up, my kids, my responsibilities, I've screwed up everything. So, I want to stop dealing with it.(530)*

> *I'm tired. I want a place. I got nothing to show for me, for my kids. I've gone through a lot of depression, even thought about killing myself. ... Because I lost a lot cause of ice. (550)*

For many, depression was most severe during the come down, and the realization that their use had caused serious problems. For example:

> *Thinking about all the money you lost, think about just ending your life sometimes, or radical stuff like that. ... The last time I felt like that was about three or four months ago. It got slow in construction and I wasn't making much money. I was still spending on Batu, but had less income coming in. I felt real down. (450)*

Drugs used to help come down from a long binging period often served to exacerbate depression and suicidal tendencies.

> *I've had several suicide attempts. I took 40 Dalmane's and 40 Valium's and a fifth of brandy. Somehow, I jumped in the Bay with no clothes on! I was rescued and taken to the crisis clinic where I stayed in...lock-up for a few days. ...Another attempt was when I shot all the dope, hoping to die. I shot Dilaudid's and Valium's and drank a lot of alcohol. I woke up the next morning and was surprised to be alive! (055)*

A respondent with a long history of poly-drug use, believes his psychological problems started after he added ice to his repertoire of substances.

> *It was the one that broke me down. Mentally, spiritually, emotionally, it's the one that led to my longest prison term. Led to my crazy behavior! Walking in and robbing a bank, without planning it out! Just a spontaneous thing. Heroin, cocaine, all the other pills, the ice is the one that took me down the fastest! ...when I was coming down off of it. Depression was real heavy. When I was on it, I didn't care about anything. Nothing mattered. (519)*

Several respondents, especially older long-term "outlaw" users, were able to hold off depression by creating a protective barrier we defined as the concept of "Distance." In essence as long as they were using they were able to maintain "distance" from the negative consequences which inevitably led to depression. As one respondent described it:

> *...you forgive yourself of all your mistakes and errors you made! Suddenly forgivable! It's okay cause everybody makes mistakes. That's what you say. When you're in that state, you can look at yourself and correct your mistakes* ***cause you have that distance. When you're not high anymore, you lose that distance.*** *(286)*

Another experienced user in his 50s admitted that after twenty years of using, the level of the meth high was less and the level of depression when coming down was greater. When asked to compare his use now with 20 years ago, he had this to say:

> *I think the changes were much more radical. You never try to work things out. You just reach for the magic powder. (006)*

4. Isolation and Paranoia

Isolation emerged as a very common theme among respondents in all study sites. Most described it as a gradual process. What began as a fun, utilitarian or social drug eventually led users to seek solitude. Many described staying for hours, days, and even weeks in one or two rooms at home.

> *At first, I wanted to go out and be with people, do things. At the middle and towards the end of my use, I didn't want to be around anybody! I just wanted to be by myself. My best friend was my pipe, I was happy! It never took anything from me. I blamed everything on my friends, not the drug!(469)*

Very often couples would isolate themselves together. A woman from the Bay Area describes one such experience.

> *There was a period when we went into the bedroom and didn't come out for two weeks. Somebody came and took my kids to school, cleaned my house, we didn't know two weeks had gone by until we came out of the bedroom! (070)*

The theme of isolation is often noticeable among crystal using gays. One of these respondents described how he would ready his room and his closet for his hit. He would lock himself in his (large) closet with candles, mirrors, and sex toys, use his methamphetamine, and masturbate alone, sometimes for days at a time. A masturbatory pattern, though not as extreme, was evident in many straight men and some women, who said they didn't want to bother with dealing with people, and used magazines and videos for extended masturbation while high.

Eventually, isolation merged into paranoia. Table VII-1 shows that 58 percent of males and 52 percent of females reported paranoia as a serious consequence. The proportion was higher among men where almost two-thirds of males in both San Diego and Honolulu reported this effect, compared to only half of male respondents in San Francisco and women users in all study sites. Those experiencing isolation described experiences which were remarkably similar:

> *I was seeing things, hearing things, freaking out. I was hiding in the bathroom for almost eight hours, naked. My boyfriend came home and beat me. It was dark and I thought there were mice and rats in there with me. I was screaming! (535)*

> *I see things laying in bed, staring at the wall or ceiling. I look for shadows and get paranoid. Be peeking out my window every five minutes! While everybody else is asleep, I'm thinking somebody is going to steal my car or stuff like that. (248)*

A bisexual woman user in Honolulu described what happened after a while:

Zombie, zone out, look out the window, be paranoid! I lived on the 23rd floor, I don't know how many ice pipes I threw out that window! I was gonna quit every day! (469)

Respondents reported that dealing often went hand in hand with paranoia:

If it was daytime, we'd close the windows and drapes and turn on a light. We'd go into the bathroom or bedroom to smoke. Where we smoke would be determined by how paranoid the dealer was on any given day. (468)

5. Psychosis: Anxiety, Hallucinations, Schizophrenia

A very serious consequence reported by a majority of respondents in all three sites involved increasing anxiety often leading to psychosis accompanying use especially heavy use and prolonged binge episodes. Table VII-1 reveals that although 56 percent of males and 59 of females overall stated that their meth use led to anxiety, it was significantly higher among respondents in San Diego with over 74 percent of women and 68 percent of male users reporting anxiety as a serious consequence. Those least likely to suffer anxiety were females in San Francisco (46 percent) and males in Honolulu (46 percent). Several respondents illustrate how increasingly high levels of anxiety while high on meth led eventually psychiatric hospitalizations:

I'd go off on runs. The more runs you take and the longer you go, you get lost! After a few days, I'd get lost! ... You can't find your way home. You don't know where to go, I'd hitch hike and be let off in these weird places! I was really getting lost. Once they came and took me against my will. All I wanted ... was crystal, I had been up way too long. I was babbling, talking to no one. The people with me said to go with them to the crisis clinic and get a shot of Valium, then I'd go to sleep and be fine. I went with them and they made me stay, I was in lock-up for five days. (055)

Because of my drug use, I have drug induced psychosis so I have to be on medicine now to keep the psychotic episodes at a small level. ... When I was 19 I was doing an ounce of crystal a week. I had a blackout for 11 days. When I realized that time had gone by, I went and checked myself in to CMH to get help. I stayed there for 3 weeks. But then I went to all kinds of out-patient every day. But I was getting high then. In April of last year I started shooting crystal again and got a drug induced psychosis. A little person was sitting there talking to me and telling me to hurt people and crash cars into bridges. Just do real bizarre shit. (289)

According to one woman, this is an inevitable result of heavy use.

I think if they legalized every drug on the market, that speed freaks would still be a minority. Because 98% of people's brain chemistry cannot handle it. Long term especially. Within 3 months of steady use, they'll have a truly psychotic episode where they'll think there's bugs coming out of their skin or they'll get paranoid. Really flip out! Then they figure out that they can't do it or they keep doing it and they have another episode and then they stop using it. But then again, there are all those people who are psychotic and just keep using it! (059)

A substantially high proportion of respondents reported experiencing hallucinations. In Table VII-1 findings for the sample as a whole, show that 70 percent of males and 63 percent of females experienced some form of hallucinations. These problems were highest among the respondents in San Diego: reported by 81 percent of male users and 78 percent of female users. Although Honolulu respondents reported the lowest incidence of hallucination (58 percent of males and 57 percent of females), this may be reflective of the cultural biases and misunderstandings in defining this concept. Moreover, many Honolulu respondents described hallucinatory experiences in the taped interview. For example:

> *Sometimes I hear like my grandfather or you hear like people talking. You get that kind of feeling that someone is watching you, like when you walk out the door and you hear people talking. I hate to go through that. (550)*

Some users felt that many forms of psychosis resulted from adulterated and poor quality methamphetamine.

> *They're not getting the pure product that we got in the '60's. Most of the shit you get now is bathtub crank. Instead of giving you energy and creativity, you get rattled and weird and paranoid and tweaky. I hate tweaky! I get horrible side affects, so much so that I don't do it very often cause I started hearing voices that aren't there. I got real paranoid. I can read people's minds, it opens up something in your brain that allows you to hear other people's thoughts. I don't know why. ...Yes, I can hear their voices saying words. Then, I get really paranoid! I used to believe the hallucinations until I realized they were hallucinations! (055)*

A user with phenylacetic poisoning on his hands from excessive meth use, developed an accompanying psychosis along with the infection:

> *Yeah and my hands were like hams.. I was so tweaked, I thought they were worms, but I was scraping them off, thinking that like I was a crank machine, and I was going to save this stuff and sell it. I thought I was producing crank, I was so spun out, it's silly. ...It's like a milky discharge, ...it's something my body did. My hands were so swelled up, they were cracked on the back, my palms were cracked, it could have been an infection or anything coming out, but I was scraping it off and putting it on a pyrex dish. I was thinking, hey, I shoot it in and it comes back out. (108)*

A number of our respondents reported what could be interpreted as psychotic episodes in their background, before their use of meth. In some cases these problems were linked to very disruptive and abusive family situations. Others remember being the "black sheep" of the family, who was often sent away to live with relatives or, eventually, to an institution. For the most part, these respondents suffer the greatest levels of psychotic problems with their meth use. A small number of these have schizophrenic symptoms, perhaps associated with their heavy meth use. In a number of cases, however, these symptoms have persisted after the use of methamphetamine ceased. (focus group notes, Honolulu, November, 1993)

6. Anger and Violence

Our findings revealed substantial levels of violence due to meth use among respondents in all study sites. As seen in Table VII-1, 44 percent of males and 33 percent of females state that their meth use led to violent acts. There was a substantially higher proportion of both male and female respondents in Honolulu who became violent due to their meth use. Among males, violent acts were reported by 53 percent in Honolulu, compared to 42 percent in San Diego, and 37 percent in San Francisco. Among women, the differences were even larger, with 44 percent of female respondents in Honolulu reporting violent acts due to their meth use, compared to 37 percent in San Diego and only 18 percent in San Francisco.

Results from our qualitative data were able to explain the context and rationale for these quantitative findings. For men heavy use over time seemed to result in a progressive deterioration of their sense of masculinity. Thus, they were more likely to act on their irritability and paranoia through violence. One male ice user who was also a heavy dealer at the time reported this process from paranoia to violence:

> *Because of the paranoia. I was hearing voices and things that I would normally not react to, I did react. ..I'd start asking questions and if no one could answer them, I'd accuse them of playing with my mind. Then, I'd start to hit my wife or my son. (461)*

Violence, usually in domestic situations, was one of the few remaining ways of expressing their maleness. As one 39 year former dealer explains:

> *Guys that do crystal meth, I knew them once as mellow. Now they use meth and I see them beat up their wives. I see them beat up their kids for no reason, just because they're irritable. Maybe they can't afford to pick up their next high. Pressure is on them, behind in the rent or the kids need this, and they can't buy it. Not only more violent verbally, but physically too.... They get into more fights because they owe their dealers money. They get beat up! All because of crystal! (429)*

> *I would snap at anything! If things wouldn't go right, before I could just let it ride, and not be angry about it. When I started taking ice something got in my head and I'd get mad. I'd smash things at the construction site if things didn't fit right. I'd get so frustrated. A lot of contractors around me...used to think I was nuts. (450)*

Some users, however, did not see their meth or ice use as the main cause of their violence:

> *I did more bad things when I was doing coke, more mugging, rolling and robbing on coke than since I switched to ice. Ice keeps me relaxed, calm, not as paranoid. Unless I overdo it. As long as I do my limit, I can handle the ice better than the coke. (535)*

In San Diego, violent behavior was often associated with confrontations in the context of dealing and distributing. For example:

> *My brother disappeared for a time period. I got worried that some guys were holding him at gun point, making him cook crystal for them. I got the word from this person and he didn't want to tell me where my brother was. I had him at gun point and I busted his face up pretty good. I busted his nose and left him laying screaming on the floor. When I went to the place where they were holding my brother, I busted in the door shooting! A lot of gun fire. ... They*

had my brother tied up in the room. He was in pretty bad shape. He was almost dead. The three guys that were holding him, I pistol whipped them pretty good. We just left. I never did any crimes like stealing. Just defense things. (326)

One male respondent describes a violent encounter with a dealer:

I went to another dealer once, a crystal dealer who was screwing my girlfriend... I went to his house to take his crystal from him, put him out of business, and beat the shit out of him for screwing my girlfriend! I was just going off, high on crystal. ...someone tried to rob my buddy who is a cook and a dealer, while I was there. They came in with guns. I came out of the bathroom swinging! I took the shotgun from the guy and smashed him in the head with it! As hard as I could! I hurt him pretty bad. We dragged him out front and left him there. We got his guns. We went and beat some guys up who were his friends. That was fun! (335)

These violent episodes tended to occur more during the come-down phase of the high. One dealer in Honolulu who averaged 72 hour binges, reported:

Towards the end, I got more violent when I was coming down. I'd drink after, when I was coming down and had no more to smoke. I'd drink myself to sleep. I would just sleep when I was coming down. I'd get very irritable and angry when I was coming down. (469)

Women are usually the victims of violence. A male user describes particularly violent attacks on his girlfriend as meth induced:

I wouldn't have been as sick, I mean I did sick things to both of them. I was kicking him in the teeth, kicking him in the face. She'd tell me not to and I start doing it to her. ...I threw her out, I slashed that guy's tires, smashed in his windows, made him drive the thing away! She was still tied up on my bed. I proceeded to fuck the shit out of her, humiliate her, and humiliate myself. I've always loved to fight. I just realized this the other night... Well, most is directly related to crystal. (335)

Women spoke of husbands or boyfriends who became violent during or after heavy binging episodes.

I've been hurt a lot through drugs and alcohol, and ... through drinking, through rapes, getting beat up, men hurting me. Just people that just, that I hang around with. (292)

He did get violent against me ... I attribute that to being up for 5 days. He was taking too many of his detox drugs and not sleeping or eating and doing speed all the time. He went nuts! He went crazy visiting his mom. He got real skinny, it was vile! It was hurting me and our son. I couldn't stand for that. Guys tend to get completely psychotic on speed! ...Men are bigger and their violence is scarier. I had the cops, the whole thing! ... All speed induced. Real bad news. (017)

Our findings show, however, that it is not uncommon for women to get violent as well as a result of heavy ice use. This is especially true for women in Honolulu as seen in Table VII-1.

People that know me don't want to fuck with me. I'm not bad or I don't act tough, but they know my background. They know my cousins. Nobody has ever tried to fuck with me yet. I'm waiting! (445)

I have been arrested. A guy hit my son and I went off the wall, I beat him up! He called the cops on me. I stayed in jail, I had to bail my own self out, I was in there 4 hours! I had to go to anger management classes! Me! Can you believe that? It was either that or one year in jail and pay $1000 fine. (455)

7. Context and Continuum

As seen in the discussion above, none of these negative episodes takes place in a vacuum. What is revealed from our depth interviews is the all encompassing way these problems interact within a person after prolonged heavy use. Very often when asked if their meth use led to a particular problem, such as paranoia, the respondent would provide a contextual description of a relentless continuum of ever increasing frustration and pain.

The following quote is a good illustration. A 30 year old male respondent in Honolulu lives with his girlfriend who is a prostitute and a dealer. A heavy polydrug user with a criminal record, states he got into meth because it was "available" through her, and because he likes the sex. After responding to questions concerning the positive aspects of meth use, he immediately began describing a web of problems caused by his meth use.

The way it makes me violent. The way she manipulates my mind on it. Because I can't think and she knows it. So, when we argue it makes me unsure of myself. It makes me stupid, it makes me so I can't reason. The arguments get more and more violent. It gives me uncontrollable rages sometimes; where I'm shaking and I want to kill! I'm that far gone. I came pretty close to hurting her. It makes me feel insignificant, unsure of myself. It's real easy to snap on it. ... It makes me intensely angry. When I get angry on it, I can taste it in my mouth when I'm snapping. (529)

He then went on to provide more detail describing myriad consequences which occur only when he injects meth, rather than smokes it.

But when I shoot it, it makes me stupid, instantly! That's the effect right after. ... it makes you stupid as hell! If you have something you have to do in a hurry, it ain't gonna get done. Don't ever do it under stress! It makes you stress real hard. You run yourself ragged on it. You can't understand what people are saying... It makes me really violent, makes me real insecure. It makes me think that people are saying things that they're not. We get into a lot of fights on it, me and my girlfriend, and they never make any sense! I've had people tell me that I was making absolutely no fucking sense at all! It makes you scatter brained, real bad. You talk to yourself. This is after long-term usage, it took me a while to get like that. (529)

Finally, a user from San Diego speaks of the convergence of several effects from long-term heavy use by his friends.

Yeah, I've seen probably worse case scenarios that people who, pre-meth use were your average normal people. Actually they were over -achievers and once they were introduced to the culture and really dove into it, turned into hermits that never rarely left their house. It would maybe take them maybe three hours to do a task that should have taken them twenty minutes just because meth affects you in a way that you get tedious and I guess you call it wigging out. Go to wash your motorcycle and you end up taking it apart because you think you see something wrong with it or stuff like that. I've seen major paranoia. Guys would say, 'Do you see anybody following you? Don't say this on the phone, don't say that on the phone. They have my phones tapped.' I think paranoia also has to do with the seclusion part of it. They feel safe in their house, therefore why leave and expose yourself to possibly getting arrested, even though you're so paranoid they don't carry anything on them personally. ***It's done some pretty remarkable things to fairly normal people.****(254)*

D. High Risk Behavioral Consequences

1. Meth Use During Pregnancy

Most women reported ceasing meth use during pregnancy, although Table VII-3 shows that approximately 35 percent of the female respondents in the study stated that they used methamphetamine while pregnant. However, there were marked differences reported across sites. The lowest proportion was found in Honolulu, with 26 percent of women users reporting use of methamphetamine during pregnancy. In San Diego, on the other hand, 48 percent of women users used meth while pregnant, with 30 percent doing so in San Francisco.

Those women who used meth during their pregnancy tended to rationalize their behavior in several basic ways. Many thought that as long as they cut down on their use, maintained a nutritional diet and ceased use several weeks before they were to give birth, they could avoid negative consequences. Even then, however, they found several difficulties. In Honolulu, one women reported physical problems due to ice use after she became pregnant.

I got pregnant a couple times. That caused a lot of problems for me. I got kidney infections from the ice, my lungs were messed up, I had a mean cough. Deep cough where I coughed stuff up. ...I went to a gynecologist and he told me I should go into a drug program! He saw it...I was so sick during that time. I was throwing up and still smoking. Morning sickness lasted all day. My lungs and my eyes suffered the most. (469)

All of these problems did not cause her to quit her use of ice, instead, she reported:

I decided not to carry the baby. I had been using progressively, I was smart enough even then to realize how much damage I had done to the fetus! Plus, I wasn't ready to have a child. ... they took me into the hospital for the abortion. I was four months pregnant. From all the sex I was having, I was having bladder infections and lots of female problems...I wasn't taking care of myself at all, I wasn't eating. Going days without sleep and not taking vitamins, it did wear down my body. (469)

Another respondent used during both of her pregnancies with serious physical consequences at each birth. Although this woman claimed she tried to quit during this time, she used daily during her first

pregnancy and averaged three times a week during her second. She claimed she never worried about the health of the baby because,

> *I didn't think there'd be anything wrong with them cause I knew several other people who used crystal during their whole pregnancy and there was nothing wrong with their children. So, I thought... They stopped using it a couple weeks before their delivery. (328)*

> *I think when I was pregnant with my child, I didn't know I was pregnant and I was having a period that I believe was from doing crank. I was bleeding while I was pregnant, I was using. I was working in a bank at the time and I did a line or two every day. Once I found out I was pregnant, I was gonna have an abortion cause I knew I had been using. I was doing two and three lines a day.... The delivery about killed me, I was tweaked when I delivered. (070)*

For this woman, like several others in our sample, their meth use resulted in premature births:

> *She was born three weeks early. I did a line and an hour later my water broke. ...I was stressing the baby. It was God telling me that I wasn't gonna get away with this! This was going to be my last line, three weeks before she was due. I probably could have gotten away with that, it wouldn't have showed up. I'd have custody of her now. ... My mom got custody of her. (328)*

Many women reported beginning to use meth immediately after giving birth. This was the result of two consequences. First, many women used meth to deal with their guilt about using during pregnancy, the subsequent harm to their babies, and often turned to meth to escape guilt from the loss of that baby. Second, other women who often successfully avoided meth use during pregnancy began using soon after giving birth in order to loose weight and gain energy:

> *And as soon as I had her, it was like a week after I had her I did some wire because it was a physical thing then. I wanted to get rid of the weight. (083)*

2. Child Abuse and Neglect

There were numerous mentions of child abuse and neglect by both mothers and fathers which were caused in various ways by their meth use. A mother who said a typical week was being "*high from Sunday to the next Monday!*" stated she always lived up to her responsibilities, then admitted that her ice use caused her to neglect her children.

> *I didn't participate in their school work or sit down with them and study with them. I didn't have time for that! I hurt my babies very much. My two sons never saw that part of me. My two daughters went thru Hell but they never saw the nice side of me, they didn't have a chance. (510)*

Many mothers talked about the ways they tried insulate their children from their use, while maintaining a level of honesty and integrity. This was reported by those who did and did not have custody of their children.

I see her all the time. She's my kid, I see all of them! All the time. Except my oldest son T. cause he's in Texas in the Army. I'm an IV drug user but that don't stop me from being their mom! I think what's wrong with kids is that adults lie to their kids! You shouldn't lie to your children. If you do something, my kids have known I use drugs since they was 10. All of them know. They have never seen me use, get off, but I don't believe in that.(149)

A substantial number of mothers in each site admitted to loosing custody of their children because of their drug use. One woman whose ex-husband has had custody of her children for most of their lives, stated:

I never had my kids because of my drug use. ... we both always did drugs, but he stopped and I was living with that [dealer] so there was too much stuff in the house always so we, I refused to have them there because .. they don't deserve it and I'm very strong minded about that. They don't need to be around it, they didn't ask to be, so I didn't have them, I let my husband have them, cause he straightened up. They know I do drugs and everything else, but they know all this so it's not hidden from them, and they know why and we are just straight up. (105)

3. HIV/AIDS High Risk Behaviors

a) Injection Drug Use: A major high risk factor among our respondents centered on their IV drug use. This is shown in Table VII-3 which reveals that approximately 43 percent of 138 respondents reporting they had ever injected meth, also admit to having shared needles. Most IV users, however, seem to be aware of, and utilize the needle exchange programs in San Francisco and Honolulu.

They have a needle exchange in San Francisco. You probably know that. I go up there or I always know people that have new ones. They always give them to me. That's real scary! As a matter of fact, I just went and had another AIDS test. I have them every 6 months. Just because in the past AIDS was a big thing, I feel like it could pop up. ... It could just pop up like five years down the line, right? (002)

Even though testing positive, often respondents either failed to change their behavior, or simply refused to believe the diagnosis. This homeless long-term user, and past dealer, currently lives in a fantasy world as evidenced by his answers to questions regarding his positive HIV status and his injection drug use behavior:

I don't know how I got that. I have been shooting and sharing needles from a long time ago. Maybe they trying to say I'm HIV+, but yet, how many years my body is healthy? My doctor tells me I'm not losing weight, I'm gaining weight! I don't feel sick, not tired, nothing. ...I feel [it is a] mistake or they trying to con me. I don't believe I have that. I'd take another test and sue those doctors for malpractice! [Interviewer: When you shared needles, did you clean them?] Just water. I been doing that all my life. Once in a while I use bleach. But bleach destroys the rubber, too. These guys say clean needles and all that stuff, but, how much more do you gotta spend? You're already spending up to $30 for a needle. I get my needles for free. I have a friend with diabetes and I get my needles from him. (547)

The potential for the spread of HIV was also revealed in the high proportion of the gay/lesbian sample who reported they had tested positive for AIDS. We found that 88 percent of our gay lesbian respondents reported having had a test for HIV. Among this group 31 percent reporting that they had tested positive for HIV infection.

b) Sexual Activity: The use of methamphetamine had myriad influences on the sexual behavior of our respondents. Our findings reveal a sexually active sample, with most having multiple sex partners in the year prior to the interview. Findings in Table VII-3 reveal that 65 percent of San Diego respondents, followed by 61 percent in San Francisco, and 53 percent in Honolulu report two or more sex partners during this period. In addition, 35 percent of the 74 gay/lesbian respondents had over 10 partners, compared to 7 percent of the heterosexual population.

The overwhelming majority of respondents in all sites stated that meth use increased their sexual activity. This was highest among San Diego users (81 percent) followed by San Francisco with 76 percent, and Honolulu with 65 percent. Similar patterns were found among the gay/bisexual sample in these sites. Findings on Table VII-3 also show that a substantial proportion of respondents say that their use of meth also changed the **type** of sexual activity they normally engage in (52 percent in San Diego, 42 percent in San Francisco, and 28 percent in Honolulu). According to Estep and Macdonald (1993), respondents reporting difficulties with sexual performance, injectors, and those with heavy levels of use were more likely to turn toward high-risk and "kinkier" sex behaviors. Mentioned most often were sexual activities with strangers, group sex, unprotected sex, and sadomasochistic behaviors. Data from the taped interviews provide contextual examples of different types of high-risk sexual behavior. Among ice users in Honolulu, for instance, meth was widely reported to increase disinhibitory sex behavior. Some examples:

> *I tell you this, I would be selling my own soul, my own self-respect, dignity for Batu. My friend ask me if I want to fuck after we do Batu. I said "yes!" We go downtown and these girls are the age of my little sister! Almost like what they do up in the States. The difference is with crack, they down in seven minutes and they go to sleep. This Batu, you don't need another hit. (465)*

> *Yeah, menage a trois. She lived with us and we loved each other. ... it was wonderful!.. The triple X rated movies were great, too. We wanted to do everything and anything! ... I'm not a jealous person, having a third person was never a problem. Next morning, everything was okay, nobody goes home feeling like shit. It was always just fun! As long as everybody is having a good time, meth helps you to do that. Meth helps you to break thru that barrier of what's right and wrong in people's minds. ...I went to a few gang bangs [While using meth] ... It's okay, it's more like a party. There's no real emotions. (055)*

In addition, 53 percent of gay/lesbian respondents in the study stated that methamphetamine use caused them to change the type of sexual activity engaged in. This is significantly higher than the percentage of heterosexual respondents (38 percent), and often involved increases in higher risk sexual activity. For example, one gay man in San Francisco spoke about an early experience involving two other men. They showed him how to use the drug anally by mixing it with water in a syringe without a needle. Known as "booting" it is said to enhance anal intercourse. Although not his preferred sexual position, he did enjoy the experience:

I have had probably eight times in my entire life. That's how often, I don't play the bottom role. But, once administered that, it turned out that I was, being the smaller of the three and the two other men were pretty nicely large and healthy endowed and they were lovers and I felt pretty safe with them. After a while, we, the speed really does turn you on, you loose your inhibitions and if you feel trusting with the people, they totally filled me up real nice! Repeatedly, several for six or eight hours. Little breaks in between but then, naturally, we booted up again. It was wonderful! I've been wanting to see them ever since! (011)

Other gay males report being turned on by IV meth use. A IV user in San Francisco who is currently suffering from AIDS has no doubt about the lethal combination of Meth and the gay community. He states:

It's the main reason why there is so much AIDS out there! People do things that they wouldn't do otherwise! (121)

There is also a substantial minority of users in all three sites who reported engaging in prostitution. This includes 30 percent of males in San Francisco, most of whom are gay or bisexual. It also includes 28 percent of women in Honolulu, providing evidence of the scope of women acting as "batunas" in this site. Moreover, the 16 percent of males engaging in prostitution in Honolulu is an indication of the existence of a substantial population of gays, many of whom are transgendered, accounting for almost half of our gay male respondents. Known as "mahous" they are often from Filipino, or Pacific Islander ethnicities.

4. Criminal Behavior/Illegal Activities

There was a very high proportion of respondents who reported engaging in one or more criminal activities: over 94 percent of males and 91 percent of females. The most commonly mentioned are found in Table VII-4, which shows burglaries, assaults and boosting/shoplifting to have been more prevalent among males overall, especially those in San Diego and Honolulu. It is also interesting to note the differences in these crime activities reported by women according to site. Burglaries and boosting/shoplifting are highest among women in Honolulu (30 percent and 65 percent) compared to women in San Francisco especially (23 percent and 38 percent). For many of our respondents, their criminal activities had a history apart from their meth use. A male from San Diego describes a typical pattern beginning in his teens with a marijuana arrest.

It wasn't mine! They said they seen me throw it away. It was a friend's, it wasn't mine, but, I got arrested for it. I was 15. I was arrested at 17 for minor in possession of alcohol. I was in a car with a 1/2 ounce of Seagrams on the seat next to me. I was also arrested at 17 for petty theft, littering, destruction of city property with the alcohol charge. Since then, I was arrested one time but no charges were filed. Child abuse charges but it was never proceeded. spousal battery but nothing came of it. (271)

Most users had histories of small scale crime activities.

We walk around all day long. We scope out the inside of cars. Leather jacket on the seat, a backpack that looks like it might be profitable to go thru. A ladies purse sitting on the floor boards or on the seat. Once we spot it, we check out the area to see if it's cool. Who's on

the sidewalk, what cars are coming up, if there is security in the buildings around us. Who might see us. (039)

Many others in all sites, both men and women, described prowling the streets to rob and/or beat up whomever they chose. These seemed to serve a dual purpose: provided a release for the anxiety and violence accompanying heavy use, and provided revenue or goods to trade for more meth. For example:

> *Stealing wasn't the only bad stuff I did. I used to roll people over. Knock them over the head. How I knew this person had money was scope them out for half hour or so. ... I didn't know the person, I just seen him and he had a pouch around his waist. It looked really fat. So, I took a chance, followed him and he went into a dark alley or a hallway and I came right behind him and give him a blow! Right behind the neck with my forearm. He'd go down and I'd take his waist pouch and take off. .... I was desperate for this ice stuff and I had to pay some bills. I used to rip off cars, too. I used to steal from my family and trade it for drugs or hawk it at the pawn shop to get drugs. (509)*

A substantial minority of respondents, however, did report having one or more felony convictions. This involved approximately 40 percent of respondents in both San Francisco and San Diego study sites, and 30 percent of users in Honolulu. One such respondent spent a considerable time in state prison, was a member of the Aryan Brotherhood, and affiliated with Bikers, reported heavy meth use both in and out of prison. He maintains that the meth-induced aggression was a major factor in his chosen field of crime--armed robbery, and assault. This was the method he used to fuel his insatiable need for large quantities of meth:

> *At this point too, I've become such a predator, if I want it I'd get it. If you got it and you're not going to give it to me, I'm going to take it. If I have to shoot you, I will. And if I think you might retaliate, I'm going to shoot you anyhow. During the two months, I started doing robberies. I didn't need the money, I had lots of money, I had a pocket full of money, I started doing the robberies, what I would do is, I would get some dope, I'd have a driver pull up to a place I was going to rob, I was 136robbing bars, and, cause I knew bars had guns in them, and this is a weird trip here, I would slam a gram, you know, that was the thing, and I would slam a gram of the raw dope, and I would be in the bar, have it robbed, and be back outside before my call was through. That was a drug in itself, the meth mixed with the fucking adrenalin high. And I didn't need the money, I gave most of the money to the driver. (108)*

Those respondents who reported committing the most serious crimes were more likely to describe these events as a result of their role in the distribution, sales, and/or manufacture of the drug.

E. Social Effects

1. Employment

For many users who first tried meth to improve their work capacity, increasing and prolonged use had the opposite effect. Table VII-5 reveals that job related problems especially affected male respondents in San Diego (47 percent) and Honolulu (43 percent). Among those groups with a higher proportion either receiving welfare, or with established *illicit* occupations, the effect of meth use on

their jobs was much less. This is especially true for respondents in San Francisco (only 23 percent of females and 29 percent of males) and for women users in Honolulu (26 percent). The qualitative findings reveal several different ways these problems develop. One of the most common was simply that the user became increasingly dysfunctional after increasing use, especially after transition to a stronger mode of use. For example one respondent described the difficulties encountered as a hair cutter when she switched from snorting to shooting meth, and binging for longer periods of time:

> *You do become dysfunctional. You shake real bad, that's kind of hard when you're cutting hair! ... After doing it for a couple of days, [you] definitely become slower. You think you're going fast but you're going slower. At first you're going real fast and then the more you stay on it, you start slowing up and then you're hands start shaking and your vision gets blurry. (002)*

> *Yeah, you know I was working at this time. I was a carpenter and I worked pretty good during these times. Except, this was when it really started having problems cause it would affect my work. I'm sure I'd be a lot more further along in my trade if I hadn't done that to myself. You'd go back to work on Monday and be like fucking attack of the living zombies! Monday's would be where you tried to get through the day. (207)*

A Latino in San Diego who began using meth from his boss at work, eventually lost his job because of his meth use:

> *I lost a job cause of meth. Cause I was always needing meth to go to work. At work I was always under the influence of meth. My boss noticed it, he knew what was going on. I'd use at work and the next day I wouldn't show up. Cause I was coming down, or I didn't have no more to go to work on. Sometimes I'd just take off from work in the middle of the day. (248)*

> *I was only doing it on pay day at first. Weekend things, I'd buy 1/4 gram and smoke it with one other guy. That would keep me going for almost two days. After that I got a different job and lots of the guys at work smoked ice. I smoked with them at work, putting in overtime. I started doing more. I quit that job cause I wasn't getting paid on time and my boss was using ice also. He was in debt and my last day of work I stole $600 from him. (003)*

A San Diego construction worker from the east county who experienced increased energy and confidence when first using, described how he eventually lost control over his use, and his job.

> *I thought I could at the beginning it wasn't too tough but then I started smoking more and it got to where that line would like you know, "oh that high is so good, o.k. I gotta go to work," I'd smoke way more than I need to and it wouldn't, then yeah o.k. I'm perfect, and I'd get to work and I'd just be WAY WAY past perfect, I couldn't think, I couldn't deal with people, it was out of control. (296)*

2. Financial

One of the most commonly mentioned negative consequences of meth use among respondents in all three sites was financial. Table VII-5 shows that overall 53 percent of males and 50 percent of women reported serious money problems as a result of their meth use. The problem

was significantly more prevalent in Honolulu with 60 percent of males and 61 percent of females reporting this problem. It was also significantly less prevalent among users in the San Francisco Bay Area where only 39 percent of women users and 44 percent of men stated this was a serious problem due to their meth use.

> *Every time I'm off the high, I say I'll never take Batu again cause I spend so much money! .. You think you can do things when you're on the drug, you can make up the money you lost, but you don't. You end up in the hole. Then you think you have to quit because you're spending too much money. Three days later, if you got money, here you go again! You keep on going like a cycle. (450)*

> *I always knew how much I had to make and then I made it. My stash was always separate. The lines got crossed towards the end, I started abusing it real bad I didn't care who I owed money to! I was using too much. I made my wife steal money from her company to pay off my debts. (461)*

Many respondents who reported getting their meth free from friends initially, later found themselves in debt to the same "friends."

> *From a friend. He had plenty and turned me on. When you get the drugs free, you take them! After a while I started spending money on ice, like $50 to $75 a day. Then I started spending $100, getting more and more ice. I was spending $1800 every two weeks on ice! I was trying to smoke for free, you always think you can make it back in profits. But you don't. (450)*

3. Spouse/Lover and Family Relationship

Among the most serious negative social consequence linked to meth use by our respondents involved relationships with a users spouse or lover. As seen in Table VII-5, over 50 percent of male and 60 percent of female users overall reported this a serious problem. This was slightly more commonly stated by women in San Diego and Honolulu (65 percent reporting yes in both sites), and slightly less a problem for males in the San Francisco Bay Area (44 percent reporting yes).

Family problems due to meth were reported by 45 percent of male and 53 percent of female users overall. Again, users in San Francisco were less likely to report that their meth use resulted in family problems (28 percent of males and 39 percent of females). This underscores the marginal status of users in the Bay Area compared to other sites. For many respondents, especially males in Honolulu, several negative consequences merged to have a devastating effect on their families.

> *Later in my addiction, I started to get abusive, more abusive than ever! Cause of the paranoia. I couldn't handle it. My wife was trying to help me quit but I didn't listen. The greed and my addiction got the best of me. My life with my family started to deteriorate. My son started doing his own thing cause he seen me doing my own thing. I was too busy to notice that my family life was falling apart. It deteriorated slowly. I wasn't paying attention to my family, I was just concentrating on my using. She would come home from work and I'd still be smoking. When she got up to get dressed for work in the morning, I'd still was up smoking... When she did voice opinions later, it was too late. I was too far into the addiction and making money. Twice after that, she tried to get me into treatment. I never went. (461)*

Another male user in Honolulu described how his heavy drug use led to the loss of his job, followed quickly by the loss of his family.

> *I lost jobs, I lost my family, lost my house. ...I stayed partying and didn't go to work. I never used to call in cause I was high and I'd lose the job. I lost my family cause I never used to come home. My wife got mad and tossed me my clothes was out the door. ...She told me she had enough of my shit and that I wasn't giving a shit about her and the kids. I was mostly getting high and drinking. ...On paydays she would come down and pick up my check. She'd give me $40 or $50 from my check to party with. I figured it was okay to party and not come home cause she had the check. But she never liked the idea that I never called her up to tell her where I was staying or what I was doing. ...On my days off I took of with the guys and partied instead of being with the kids. (517)*

According to a female respondent in Honolulu:

> *It's made a helluva scene of our relationship! I hope we get straightened up and clean so we can get to know each other! When we're on ice, we're two different people. Bad. Suspicious. I can't hear and I think he's saying something! Every problem we've had has been from ice. (530)*

These problems were particularly serious in gay and lesbian relationships. According to a lesbian user in San Francisco:

> *There's more fighting, less patience. When there's a drug involved in a relationship between two people, it's like a third person is involved. Sometimes you have to chose whether you're going to spend time with her or you're gonna be high. There were times that I wanted to use and she wanted to be with me but not high. It would cause serious conflict. There are numerous times that a lover has said I'd rather be with my drug than them! There were times I said, yes, it's true. (132)*

4. Problems with Friends

Table VII-5 shows that over half of our respondents reported problems with friends due to meth use (52 percent males, 55 percent females),but with significant differences across study sites. For example, 63 percent of women in both San Diego and Honolulu compared to only 36 percent of female users in San Francisco reported problems with friends resulting from use. The differences are similar comparing males in San Diego and Honolulu (56 and 57 percent) to males in San Francisco (28 percent) reporting meth caused serious problems with friends. A Hawaiian women describes what happened when she began to deal:

> *They wanted ice, food, everything from me! I love to help. I was brought on to this Earth to help people! But I took it in the wrong way! People started taking advantage of that and I stopped dealing finally. Then all of my so called "good friends" seemed to become my enemies because I wasn't there to support them anymore. I wasn't there to give them the dope that they wanted anymore. So they all went against me. It got to a point where I don't trust anybody. My heart grows harder and harder. I've never, ever felt like this in my life! I've always been laughing and merry, making jokes. I feel mean toward people now. (449)*

I had a real problem with my drug use because in order for me to use, I had to get it so that you would use too. A lot of people that I cared about, I feel like by being their connect I made it too easy for them. I feel guilty that because of me, they were getting loaded too. People tell me that's not the case, but I still feel that way. (289)

When asked about relations with his friends, one dealer in Honolulu replied:

The things I was doing, the guilt and I couldn't look at myself in the mirror no more. Cause I didn't want to see myself, knowing the things that I had done to my family and to others. (403)

When asked how his use of ice affected his social life, one respondent in Honolulu stated:

I've met more people. I'd like to meet more straight people though. Because people on Batu are always playing games. My social life has just changed in general. I meet strange people. This drug hasn't worked very well between me and my spouse. We been separated for two years now. (445)

There are people who do drugs and do really bad things. There are people who do drugs and DON'T do bad things and maybe it does lean towards the type of people who do bad things when they're on drugs. Or because of drugs or to get drugs, but, there is the minority, I hate to say minority, I think it's the minority of people anyway that don't do fucked up things to other people. I don't think it has anything to do with drugs. Basically, people that are decent people are just a minority these days. I hate to say it! I sound like a total pessimist. (059)

5. Community/Societal Disenfranchisement

One respondent who has lived in California before moving to Honolulu felt strongly that Ice had a significantly more negative impact on the social networks in the community than it did in California communities.

Ice costs are so high and the dealing with the people, they use it for the power here. It's a power play, whoever has got the most is in the lead! It's kind of a game people play. It really gets disgusting when you're spending every dime you have for ice and some of the things you do for it, to deal with people's power plays! A lot of people get hurt, ripped off, things taken from them that mean a lot to them. Over here, there's no loyalty. No brotherhood, everybody rats each other off, they all steal from each other for the ice. I know brothers who steal from each other for the ice. Then a week later, they're all friends again. ...Everybody I met here that did ice, nobody worked! But they all paid for this drug! There was no loyalty, no dreams. They're all like dead here. ...I can see myself falling into the same category as they are. No life, no dreams, the only thing that matters is ice. (530)

Another respondent from Honolulu provided an even more grim portrait.

A lot of the violence going on in Hawaii, people hurting their families, I know if you interviewed those people, that have murdered people on that shit, people they supposedly loved, they'd tell you about ice stories. real bad, they probably didn't realize what they were doing. It's

happened a lot over here, lately. I think somebody should talk to those folks, find out what ice they were doing. I guarantee that every time we see that on TV, we all think it was somebody fucked up on ice! The rage is just fucking, flipped-out rages, man. The people I meet on it that deal it or do it, they're real scary, they have real dead eyes! I don't think they feel anything for anybody! (529)

The following woman describes how ice has destroyed her social world, even though she herself has no intention to quit.

I see a lot of things going down with ice. A lot of my friends get all busted. ... Either my friends go in a hole big time, going to prison, they get into trouble. A friend younger than me just passed away a month ago. his girlfriend shoot him, he die! ... I heard that a deal went bad. She had to do it, they were gonna shoot her or him, she had to do it. ...He was a local boy, a good solid friend...real gangster kind of brothers, but they not make trouble to me or my family. ..the same friends still on the same run, or in programs! My close, close friends are in prisons or programs. I really messed up our lives.(459)

An important finding emerging from this study concerned the effect on individuals and communities from the scarcity of marijuana due to the eradication campaigns. Users often reported this was a major contribution to the increase in the use of meth especially in Honolulu. In many communities it had a devastating effect. As one respondent stated:

The ice use on the Waianae Coast is greater than a lot of other places in the State! This is like a central distribution center for ice. It's a known fact among the drug addicts and users on the island. It's easier to get than weed! It's not much more expensive than weed, either! The amount of people here that use ice is increasing because people who couldn't find weed were starting to find ice easier! Plenty guys I know use ice because they can't get pot! I'd rather see them smoking pakololo cause they were mellow, nice people. On ice, they change into robbing houses and carrying guns in less than one month. Things they never did on weed. (468)

F. Summary

This chapter presented an extensive examination of the major negative consequences experienced by respondents in this study. In providing a systematic integration of the qualitative and quantitative data, we were able to do more than merely highlight significant issues and problems. The respondents, themselves, provided the meaning and context in often complex situational illustrations. It should be stressed that these illustrations, themselves, were able to portray a web of effects and consequences which tapped into the real-life dilemmas facing these users. Rather than a linear model of problem correlations, this chapter attempted to construct a mosaic of competing events, beliefs, and conditions inhabited by our respondents.

TABLE VII-1

PSYCHOLOGICAL AND PHYSICAL CONSEQUENCES: BY SITE AND GENDER
(percent answering yes)

PROBLEM	SAN FRANCISCO		SAN DIEGO		HONOLULU		TOTAL	
	Male (n=96)	Female (n=44)	Male (n=102)	Female (n=49)	Male (n=101)	Female (n=46)	Male (n=299)	Female (n=139)
WEIGHT LOSS	52%	57%	74%	69%	75%	89%	67%	72%
MEMORY LOSS	40%	34%	59%	59%	53%	52%	51%	49%
DEPRESSION	59%	61%	70%	82%	70%	65%	67%	70%
ANXIETY	54%	46%	67%	74%	46%	57%	56%	59%
HALLUCINATE	71%	52%	81%	78%	58%	57%	70%	63%
PARANOIA	50%	52%	61%	51%	61%	52%	58%	52%
VIOLENT ACTS	37%	18%	42%	37%	53%	44%	44%	33%

TABLE VII-2

ADDICTION AND LOSS OF CONTROL DUE TO METH USE: BY SITE AND GENDER
(percent answering yes)

	SAN FRANCISCO		SAN DIEGO		HONOLULU		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female
›st ›ntrol	37%	43%	56%	47%	58%	46%	51%	45%
›lt ›dicted	54%	59%	69%	65%	57%	63%	60%	63%

TABLE VII-3

HIGH RISK BEHAVIORAL CONSEQUENCES AND METH USE: BY SITE AND GENDER
(percent answering yes)

	SAN FRANCISCO		SAN DIEGO		HONOLULU		TOTAL	
BEHAVIOR	N	(%)	N	(%)	N	(%)	N	(%)
USED WHEN PREGNANT	13	(30%)	23	(48%)	11	(26%)	47	(35%)
SHARED NEEDLE IV/METH	44	(35%)	22	(33%)	13	(25%)	79	(32%)
HAD HIV TEST	122	(81%)	84	(56%)	94	(63%)	300	(67%)
POS/DK STATUS	27	(22%)	14	(17%)	12	(12%)	53	(18%)
10 + SEX PARTNERS/ PAST YEAR	26	(17%)	14	(9%)	16	(11%)	76	(13%)
USE SEX PROTECT/ LESS/HALFTIME	46	(51%)	43	(52%)	55	(61%)	134	(55%)
METH=INCREASE SEX ACTIVITY	114	(76%)	122	(81%)	97	(65%)	333	(74%)
METH=CHANGED SEX ACTIVITY	62	(42%)	78	(52%)	42	(28%)	182	(41%)

TABLE VII-4

CRIMINAL BEHAVIOR DUE TO METH: BY SITE AND GENDER
(percent answering yes)

	SAN FRANCISCO		SAN DIEGO		HONOLULU		TOTAL	
	Male (N=94)	Female (N=43)	Male (N=97)	Female (N=46)	Male (N=100)	Female (N=40)	Male (N=291)	Female (N=129)
EHAVIOR								
NY DRUG ALES	95%	93%	92%	91%	85%	73%	90%	8%
ETH DRUG ALES	77%	84%	88%	83%	63%	63%	76%	7%
RUG RRESTS/ HARGES	42%	26%	52%	26%	37%	5%	43%	1%
JRGLARIES	38%	23%	43%	22%	50%	30%	44%	24%
SSAULTS	36%	19%	56%	11%	60%	40%	51%	2%
ROSTITUTION	30%	21%	11%	11%	16%	28%	19%	1%
OOSTING/ HOPLIFTING	38%	42%	51%	44%	65%	50%	52%	4%

TABLE VII-5

SOCIAL CONSEQUENCES DUE TO METH USE: BY SITE AND GENDER
(percent answering yes)

	SAN FRANCISCO		SAN DIEGO		HONOLULU		TOTAL	
	Male (N=96)	Female (N=44)	Male (N=102)	Female (N=49)	Male (N=101)	Female (N=46)	Male (N=299)	Female (N=139)
PROBLEM								
W/SPOUSE OR LOVER	54%	50%	54%	65%	51%	65%	50%	60%
W/FAMILY	28%	39%	52%	67%	55%	50%	45%	53%
W/FRIENDS	43%	36%	56%	63%	57%	63%	52%	55%
W/WORK	29%	23%	47%	31%	43%	26%	40%	27%
SERIOUS MONEY PROBLEMS	44%	39%	53%	49%	60%	61%	53%	50%

CHAPTER VIII.

QUITTING, TREATMENT AND INTERVENTION

A. Introduction

Respondents had a wide range of opinions and experience concerning cessation of their methamphetamine use. Some respondents in each site had reportedly discontinued use in the past year. A larger proportion had attempted to quit at some time in their meth using career. A sub-sample of respondents had been in treatment at some point in their lives, mainly those in Honolulu and San Diego. Others reported that they had quit using on their own, most within less than one month prior to the interview. The majority of respondents in all three sites, expressed a variety of attitudes concerning their future in relation to methamphetamine. In this chapter we describe these attitudes, and their meaning in terms of the user's future behavior regarding modification or cessation of use. We then present findings on the user's quitting and treatment experiences, charting both barriers and pathways, their success and/or failure.

B. Attitudes Toward Future Use Modification or Cessation.

Respondents foresaw a variety of future scenarios concerning their use of meth. Although most believed they would continue to use, many believed they would cutdown or modify their use in some way, and others sought to quit using altogether. Over half of our sample (52 percent) stated that they had tried to quit at some time. In addition, there were also many active meth users who firmly vowed that they intended to quit in the near future. Most of these respondents acknowledged, however, that their next attempt to get off meth would not be their first such effort and most likely not their last as well. Nevertheless, along with health and relationship concerns, these respondents had grown increasingly disillusioned with methamphetamine and their particular user networks. Other felt that they were simply getting too old to continue.

1. Maturing Out

A commonly reported them among some of our respondents, especially those over 30 years of age, was the idea that they were reaching a point where meth no longer fit into their future.

> *I think a lot of it, I mean I did enjoy drugs but I guess I'm older, I guess I don't want to be like that anymore. There was always drugs between drinking and whatever I was doing. Most of the time. That all I can remember my life story, it's just drinking and using. I don't drink anymore, I don't like the hangovers or the way I act. ... cause I don't like the comedown, it gives me headaches. I like the up affect of it. I'm just to the point where, I'm 38 and my time is almost over, the younger people can have it. I'm burned out, I'm getting tired of it. (292)*

Well it's like everything else. It gets boring. It was a routine that had no future in it. It's like I would be in a rut, just the same old treadmill over and over every day, boring, the same old treadmill, same old people, same old activities, same old reasons, same old high. I wasn't going anywhere. I wasn't getting out of life what I really wanted. I wasn't traveling. I wasn't going to the Grand Canyon or anything like that. And it just kind of anchored me down to that rut and I didn't really want that kind of life. (089)

I see stopping. I see the light. I didn't think I ever would, but, I do now. It's boring now. It has lost it's excitement. I think that's because we're getting a bit older. (063)

I still see people that I did, but as you get older, I think they get sick of you more and more. Hard to explain. I gradually just faded out of it. Better to burn out than fad away! I faded away! (207)

2. Desire to Improve Social Life/Interpersonal Relationships

A substantial number of respondents spoke of (often successful) attempts to quit in order to save or establish their relationship with a spouse or lover.

I think that I loved her enough that I wanted to quit. I wanted to be my old self. I wanted her to be happy and her old self and this was the 1st time I felt emotionally close to somebody even while I was using it. I was using it, she was using it and I still felt emotionally close to her. I knew there was something there. For our sake, I decided I had to do something about it. I set a target date to quit and I think I made it within 2 days of my target date to actually quit. (205)

Another commonly reported reason for quitting was because of increasing trouble with the law, generally due to their dealing activities. Although some entered court-mandated treatment, for others, the experience of getting caught acted as a strong motivation.

I stopped using drugs because I was getting into so much trouble with the law. I got off lucky and I knew at the time that I was lucky. I didn't want to live that pain anymore, on the streets, no money, nowhere to go, degrading myself. It was all pain. (403)

3. Financial

For many respondents quitting was motivated by the financial problems connected to both using and dealing.

I think about quitting, but I got to find something to keep me busy. If you're not working and you stay home a lot, you tend to start thinking more and more. You hang with the boys when they're smoking and you be high too. There's no future in that! Unless you get a whole big, bulk of Batu to sell. If you was the main man, then it would be okay. Yeah! Make money! But as far as buying it from somebody else and trying to make money, most of the time you just smoke it up. Gone. You end up smoking your profit. (403)

C. Quitting Experiences

1. Methods of Quitting without treatment

Several respondents reported receiving anti-depressants to help them quit their meth use which resulted in a very negative experience. When asked if he had ever tried to quit one respondent answered:

> *That's my way of life! Two months at the most. That was three years ago. It was horrible. I went to the doctor and he prescribed me Prozac. I took that and almost jumped out a window! Man, that was bad. He had me try a lot of different anti-depressants, but I decided maybe I should supplement my need with some diet pills. Then I was taking more diet pills than I was doing harm with the speed! So I just went back to the speed. ...I stopped using drugs because I was getting into so much trouble with the law. I got off lucky and I knew at the time that I was lucky. I didn't want to live that pain anymore, on the streets, no money, nowhere to go, degrading myself. It was all pain. (403)*

Another respondent from San Francisco reported that the only time he/she quit for two months involved prozac as well:

> *That was 3 years ago. It was horrible. I went to the doctor and he prescribed me Prozac. I took that and almost jumped out a window! Man! That was bad. He had me try a lot of different anti-depressants, but I decided maybe I should supplement my need with some diet pills. Then I was taking more diet pills than I was doing harm with the speed! So I just went back to the speed. (094)*

2. Barriers to Quitting

Several of our respondents have talked about how meth gives them confidence and self-esteem and makes them happier people. It has also resulted in forming their social world. So quitting presents special difficulties. It's not so much that they are "addicted" to the drug itself, it's more that they are afraid they won't be able to get on their own what they have gotten from meth. For example:

> *Just trying to find a way to get off of it and be happy at the same time. I have this problem about being lonely. I don't like being alone. And that also helps me stay on the wire. So if I can get away from being alone all the time, then I should be able to get off of it. And once I'm off of it, no telling what I can do, 'cause I know what I can do. ... for me to get off of it, I'd have to get rid of everybody I know. I'd have to probably get up and move. I'd have to make a drastic change. And that's gonna be hard for me to do. It's habit-forming. Yeah, because I'd like to stop and you can't. ...like I'm divorced and I'm trying to raise three kids. There's no way one person can raise three kids plus work plus take care of this house without some kind of help. ... It's a mess, 'cause I don't have the energy. And I guess I would have to be off of it for quite awhile to get that energy back to normal, to stay off of it. (083)*

One woman who earns over $70,000 per year selling meth only by the pound, who only has to spend one hour per day at this enterprise, who lives a very respectable upper-middle class public life and who is a heavy user of meth, describes this dilemma:

> *A couple days ago I was thinking about my life and I try to honestly think about what meth means to me. It's done so much good for me, as bad as it is, it's real hard to explain to somebody the good of this drug when there really is none, but how I work it into a normal life. I'd have to totally be in the closet cause I can relate and function with normal people as if I weren't on any drugs. The minute they find out I'm doing meth, I cease to be normal anymore! I'm scum. It's a necessity for me in my world. Physical, mental, because I don't live normally without it! But I know you can't live normally with it. ...A little voice in my head always reminds me I'm doing something illegal and endangering my kids. I'd like to think that five years from now I'm gonna have a job, drive a Corvette, my kids will be in prep schools, ...I'd like to think that in a few years all the best things will be in my life. For the right reasons, too. Not because I've sold drugs. (297)*

Relationships pose particular barriers to quitting meth, especially if one partner is trying to quit while the other continues to use.

> *He tried to fake it for a while. I knew he was so high! Finally he admitted he was high! ..I wanted a more normal life. He's been in it a lot longer than I have, twelve years or something. He just, he might think he controls it. He does a little bit every day just to get by; to stay awake. That might be control to him. He sneaks. I can see it on his face. I can tell talking to him on the phone! (009)*

A homeless man in Honolulu gave this reason

> *I don't want to quit because I live on the streets. That won't stop me cause all the ice is on the streets. That's why I won't quit. But if I get me a place, then I'll stop all the drugs cause there's no drugs around. (475)*

D. Treatment Experiences

A subsample of respondents with treatment experience was drawn from San Diego and Honolulu. Although no one currently in treatment was interviewed in San Francisco, several were on methadone maintenance, and a number stated they had attended court ordered self-help meetings such as NA sometime in the past. Some also had experiences with programs as juveniles. There were 33 with treatment experience from San Diego and approximately 15 from Honolulu. It is interesting to note that respondents seeking treatment from San Diego tended to be very heavy users, and to have serious mental problems. Those with treatment from Honolulu, on the other hand,

1. San Diego Treatment Experiences

Often these respondents came to treatment voluntarily after a serious crises event. This 27 year old male IV user was averaging 10 grams per month:

Then on July 16th I overdosed on coke and almost died. It really freaked me out, I pulled myself back together and then came to and I was still twitching and it took me maybe 5 minutes for the convulsion to stop. I realized that I almost died and I called a friend who I met who I found out was in NA and said I think I need help. He took me to my first meeting and it took about 3 months after that, I was still using during that time, but I knew about NA and periodically doing meetings and then I checked into the house here, The Stepping Stone. They told me it would be a two month waiting list and during that time I would have to go to the day program. So enrolled in the day program and I was still using about the first week there. Then got evicted from my apartment and at that point I just quit. I no longer had the money to buy drugs, something in my mind really wanted me to quit. I had started putting on weight again, looking better and feeling better. The memory of almost dying was really fresh in my mind and I didn't want to die, so... I went to St. Vincent DePaul's, stayed there for a month, going to the day program and then got into the house and I've been here ever since. (278)

Respondents ordered into treatment by the courts, had an entirely different attitude. A female dealer who was also a very heavy intranasal user at 27 grams per month, continued to deny that she had a serious problem.

I was busted and sentenced July 10th. I was put in Los Colinas right from the courtroom, until a bed was ready here at S. H. My store has been closed since July 10th, I'm pretty upset about that. They're trying to get me to admit that I'm a drug addict at Serenity House because they feel I'm in denial. I don't deny I'm an addict, but I do go to food. I should be in Overeaters Anonymous! I'm fat. If I get hurt, I'll satisfy my hurt with food, not with drugs. I did drugs because it was available and I sold them. That could mean I'm a drug addict, I don't know! I was addicted to it, physically, I was really disillusioned. But, I started my business and realized that I'm not fucked up, my boyfriend was fucked up! Then I became more in control. When I got even more upset, I put the drug away and told myself I didn't need it right then. (322)

On the other hand, others saw their treatment experience as a positive move in their lives, especially if it happened when they began to see both addiction and loss of control as a reality. A young woman still in her twenties, had used for 11 years reaching a level where she would inject 50 grams of meth per month. Although she had experienced treatment without success previously, this time after a few weeks in another program she had a different assessment. When asked what the difference was, she replied:

It's the same but the difference is now, I want it. Then I didn't. This place I want to succeed. [I like the] NA book. Plus I get tutoring here for my education. Now I know words that I can read. And understand them. If I didn't have that tutoring, I can read now, I'd just go back out there and start to use again. But I have pride in me now, I can read.(340)

Another respondent had been through a series of largely unsuccessful treatment programs, including psychiatric hospitalization, out patient therapeutic, de-tox and various twelve step programs. When asked why the latest one--a County social model outpatient program--finally worked, she replied:

They kept begging me! They wouldn't lighten up on me! I thought I was hopeless. I felt hopeless. I knew I was sick. When I found out I was sick I wanted to deny it! This recovery home helped me to know I was sick and it was okay. It doesn't mean I'm non-functional. (286)

2. Honolulu Treatment Experiences

A respondent talked about how treatment offered him a way to deal with what he defined as a very difficult addiction.

You sit there and think about your life going down the drain! SO you smoke more. ... I went to rehab and a lot of things that I didn't want to face, I had to end up dealing with them! A lot of coping skills, rehab helped me. Finally, my use had dropped by that time and it was easier. I was still using here and there but once I got turned on to church, I was able to really stop. I wanted to get back on track without the use of drugs. I decided to stay that way! There are so many bad things to it. I just wanted to have fun and party but nothing lasts forever! I didn't want to go thru the experience again. The worst thing I remember was that if it ever crossed my face again, I won't think about using. I'll think about my past, what I had done and not want to go back to it. (481)

Respondents admitted that it often it took several relapses before they seriously tried to quit use. Each encounter with the system, however, seems to have left impressions on the user, not all of them for the better. This respondent reported that the main things he got out of his first treatment experience were a few tricks:

I knew I was addicted cause I had learned from treatment before. I told people I was addicted and I used that as an excuse to smoke more and more. (403)

His increasing use led to increasing consequences: with his parents, with his job, and finally with the law. This led to his second experience, which seems to have had a positive effect:

I was pawning everything, stealing from my parents. Insanity. I stole all my mother's jewelry from her and pawned it for ice. I stole my father's golf clubs, stole his jewelry. stole the family VCR. My dad had enough and called the police on me. They got finger prints on everything and I was arrested for theft and burglary. I told the detective that I wanted to get help, that I couldn't go on the way I was going. I was sick of it. But there was no way that I could use and not steal for my money. I lost my job. I was living on the streets. The detective told me ... if I went for help, they wouldn't charge me. I got help at a rehab. I'm getting out next week. I've been here almost three months. ...I don't talk to any of the guys I used to smoke with or run with. I cut them. I try to do things differently than as I did when I was on ice. I've tried to change my thinking. Cause I still do think about it sometimes. I see an opportunity come up or I could be out there smoking big time, but I don't want to fall for that instant gratification! (403)

An outpatient support service run by the YMCA for Filipino youth close to downtown seems to have made an impact on several respondents. One young woman was referred after problems with her job:

Every Tuesdays and Thursdays we had support group. They said to smoke only once a week, to drink only one day a week... It helped a lot. I went to Narcotics Anonymous and all these adults were there. I was the youngest one there. I felt shame in front of these adults. Now, we have a support group for teenagers. I been going for 1 year. The YMCA helped most of my friends, too. It helped me get off of ICE and marijuana. I stopped going finally. Now, they expect me forever! They ask my friends about me. (463)

3. San Francisco

For many users their initial treatment experience occurred during adolescence. Soon after she began shooting cocaine, then speed at age fifteen a respondent from the Bay Area described this experience:

Then I started shooting up speed. Then my parents sent me away to a drug rehab because they went to a counselor. They went thru my things and found a gold straw, razor blades, strainers, I was dealing too, at the time. They sent me to a drug rehab in San Francisco, Marshall Hale. I totally hated that place. I tried to escape three or four times before I actually got out of there. (002)

Another dealer from the East Bay was sent to court ordered treatment for a drug sales charge. Growing up with a mother who dealt heroin, this 27 year old had been dealing himself for 13 years, and carried a mountain of resentment with him when he first entered.

Four years ago the Court sent me thru a residential treatment program. CenterPoint. Eight month live-in, residential program. I graduated and got my diploma. Both a G.E.D. and my diploma from the program. They make you get the G.E.D. They rode me like a son-of-a-bitch to get it. I had a chip on my shoulder until I went into that program. It taught me a lot about who I was and I'm okay with myself. I was pissed off at the world at what it had done to me and thought it owed me something. (054)

After he discovered the value of what it actually offered, it began to work for him:

They sent me to the program and I had every intention of splitting the program and going underground. But, I liked it! [laughs] You couldn't beat me out of that place! It was great! I had finally found a place where I could relate, I fit in. ...I had to write a lot of papers about myself. Trust issues, honesty, integrity, auto-biographies. I had to read them out loud to the group. People give me feed-back about what you wrote. Writing keyed me into myself. Before I went into the program, I didn't know I had a choice. I only knew one thing, dope. Doing it and dealing it. I didn't think there was any other fork in the road for me. It was my path, I went from being a teenager right into shooting. I never snorted. A little bit of acid before that, some pot, but, I went straight into shooting it at 17. I didn't even know myself yet! I never met me before I went into the program. (054)

A substantial proportion of poly-drug IV users in the San Francisco area report going through various detox, and treatment programs, including methadone. Detox seems to be a regular activity for those who need periodic "time out" from their heroin use. It is also commonly ordered for those charged with various drug offenses. Repondents described quite diverse methadone experiences. For example, this IV user states:

Then I got on a detox program. I've been on seven detox programs. I was told that was the most detox programs that I could be on. I was doing a 21 day methadone detox from high dose down to zero. It just didn't work. I was told that I'd have to wait 6 months before I could get on another detox. I needed a two year history about my repeated failures before I got on maintenance. It took me being hooked 3 years, on the street, before I got on maintenance. I wish I never would have got on it. I heard that the shit is fucking, you go thru hell. You can't kick the shit successfully. It gets in your bones. (060)

Other respondents had more positive assessments of methadone treatment. Most, however, continued using methamphetamine throughout, often stating that it helped them through the process of successfully quitting their use of heroin.

E. Summary

Overall, very few of our respondents saw any reason to seek treatment for their methamphetamine use. One reason could be the lack of treatment services generally in the poor working-class suburbs located in both California sites. Also, since there are few treatment programs specifically addressing methamphetamine abuse outside Honolulu, most of those who did go into treatment, participated in programs aimed at problems involving other types of drugs. In Honolulu, the most successful programs for older respondents appeared to be in-patient, or dedicated to addressing the needs of targeted ethnic groups.

CHAPTER IX.

THE METHAMPHETAMINE ECONOMIC ENTERPRISE

A. Introduction

A very significant finding from our study were the numbers of respondents who reported engaging in drug sales and distributions as a result of their meth use. As seen in Table IV-3, 91 percent of male respondents and 86 percent of females reported engaging in drug sales. Moreover, drug sales related to meth were reported by 76 percent of males and 77 percent of females.

B. Dealers: Styles, Gender and Geography

1. Business Rules and Personal Control

A basic rule mentioned by many serious dealers concern protection of their home environment.

> *...never sold to people from within my home. I would have to go out of my home environment to give it to them or to sell to them. I can't bring people that are using a drug that causes such instability in their life into my home and expect my own lifestyle to stay stable. That would be a paradox within itself! (293)*

A major reason for protecting the home, was to separate family life and business, especially women dealers with small children. Faced with living on welfare after her divorce, one woman returned to dealing and now reports making over $60 thousand per year by dealing only in pounds and limiting her activity to one hour per day provides a good example:

> *I make money from sales, I never do what I need to sell. I won't take it from my kids or my rent or my food or bills, I wanted off welfare, so I began to sell again. I'm not a stupid person. I don't go around doing stupid things. I don't walk around telling people I have drugs for sale, I don't have people sitting out in front of my house, I don't have traffic in and out of my house. (297)*

A San Diego woman who dealt in pounds, did do business from home, but established a long list of rules to guide her customers.

> *They had to call first and tell me how much they wanted. They'd come by themselves. I had to know before hand that they was bringing somebody new or I had to know the person they was bringing. Nobody ever sit out in cars in front of the house. They had to come in. Nobody could hang out in front of my house. Once the deal was made, there was no hanging around, partying. You had to leave. I wasn't a party person with business, this was a business! I gave you time to try the product out if you wanted to. If you liked it, you put your money down and left my house! I couldn't take the chance of being busted with all that stuff there. (281)*

A woman of mixed Hawaiian ethnicity dealt in the heart of one Leeward side ice community. Even though ice dealing was common, and use open, in her neighborhood, she set up rules to assure her participation was discrete.

> *I was so low profile, not even my own home had traffic. I had good rules and regulations that everyone had to abide by or they didn't get none! ..no calls after 10:00 at night. No dealings after 10:00 at night. Call my house before you come over, don't just show up. If you see me out in the streets and I'm not expecting you, don't expect to score, you won't get shit! And I'd cut their line! If I say "No more nothing" they know why. They disobeyed my rules. (542)*

For some dealers the best method of avoiding an out-of-control use pattern, increasing their use, and thus decreasing profits, was to avoid selling to certain people. Other people only did business with people they knew, or who had been introduced by people they knew.

> *Even now, my business is largely a matter of acquiring, despite the fact that I can move a lot if I want to, both in quantity and in quantity of small amounts or big amounts, my business is a matter of me getting drugs and supplying a selection of a few people. I change the list of people I'm willing to supply regularly.(075)*

Other dealers limited their sales to a higher class customer. One woman from learned the hard way after a police raid based on a customer,turned informant. After that she changed her habits and her buyers.

> *I wasn't selling to anybody on the street. I was only selling and made only deliveries. Or, the people came during business hours. They were all professional people, they had money to spend on drugs, they were all employed or their husbands or spouses were employed and they did it together. That is who my clients were. People that maintained control, only! People that are able to get up and go to work every single day and still do drugs every day, I feel, can have a sense of control and maintain control. I charged them top dollar for the drug because I only had quality drugs. I wasn't that greedy. If I'm gonna sell a drug, it better be the best. These were professionals who didn't mind paying for the best. (322)*

Business and personal use control did seem to be connected. The most commonly reported ending to a successful dealing career was due to this combination. Information from our respondents reveals that the major cause was success itself. As customers increased so did the amount of drug on hand, the number of hours needed to do business, and the temptation to use more. The San Diego woman who dealt in pounds found her business spreading all over the county, with her making deliveries most of the day.

> *So, my car always had crystal in it. My purse always had 2 or 3 ounces in it. I'd go into a grocery store or department store and open my bag up to pay for things and it was embarrassing, the smell was awful from my bag! [laughs] The crystal smell was so strong that everyone could smell it! I realized it then how obvious it was what I was doing! I'd be so disorganized in my purse! (281)*

A 27 year old male dealer who learned the business from his mother's heroin dealing trade, had very clear ideas about his business rules and ethics. When asked how he would describe his fellow dealers, he replied:

> *Totally opposite from me, the other end of the scale. I had ethics, I made sure nobody got sick, no stepping on it. Me and my family are the only one's I know that do business well. No bullshit, no games, no power trips. People I sell to, they'd rather have shorter bags than cut bags. They don't want bunk. Cleaner shit. I don't front and I have basic business sense. Now, it's a free-for-all out there. Everybody out there now is getting all, whatever they can! They don't care who they step on, who they burn, who they rat on. There's no more code or ethics. That's what has put me out, both my sales commissions have been paid informants, ratted on. (054)*

2. Difference between male and female dealers

The significance of female dealers in our study is revealed in several aspects in the qualitative data. For example, it was common for male respondents to report the importance of women as dealers in their areas. As one male stated about women they were:

> *More reliable. As far as being honest about their dealings with me, I could say that they were more reliable in that sense. They were women who had children, they also had conscience. Sometimes I'd get into a serious conversation with them and you could tell that they felt really bad about the fact that they were caught in this cycle that they couldn't break out of. It was a cycle that I felt like I was caught in too. Where the men dealers were much, much less ethical and much less conscience, they had less conscience about what they were doing. (073)*

> *I worked with mainly women. Guys always seemed to mess up. Women always can control their drugs and control selling better than a man! For some reason, they more business minded. So I'd have women in Chula Vista, a woman in Spring Valley, one in the Northeast, and one in National City. Also one in the Southeast. I'd go early in the morning to their houses. I'd drop off an ounce or two with them. If they had a big deal coming up during that day, I'd bring a pound over in the morning. Then around 3:00 in the afternoon I'd go back to their house and pick up the money. If they needed more then, I'd drop off more crystal then.(281)*

Many women began in partnership with their husbands, and took over the business after his business or using habits threatened to shut it down. One Bay Area female dealer stated that after she took over the business from her husband,

> *It boomed, it just exploded! F. knew everybody but just never had it together enough because he wasn't a business type person. He was Mr. Charisma, party-party, happy-happy. I'm more grounded and business like. That's all he needed and we really clicked.(059)*

A major finding is that women dealers were the only ones to discuss the concept of **pride** in their accomplishments as dealers. The most frequently mentioned reasons centered on their achievements in operating and maintaining a competent business enterprise. Many referred to

the bias and difficulties in dealing with men suppliers and customers in particular. One woman, for example, articulated the reasons behind a strong degree of pride in her profession and in her ability to run a successful business enterprise.

> *I'm a good dealer. I don't cut my drugs. I have high quality drugs in so far as it's possible to get high quality drugs. I want to be known as somebody who sells good drugs, but doesn't always have them. As opposed to someone who always has them and sometimes the drugs are good. (075)*

Another female respondent who was formerly a high level dealer provides another example:

> *Successful people will always succeed and I don't care if they do drugs or not! There are successful people and they will always succeed. I feel I'm one of those. I turned a real bad situation around, like getting fired from my government job of 15 and 1/2 years invested! I turned that around from a very negative thing. ...I turned that around to be a positive. That was to take my money out and buy a business, re-vamp it and have a really fine, workable, collectable antique store that is respected and people desire to shop there. (322)*

Importantly female dealers tended to have an ability to articulate an ethic which structures both their enterprise and which also speaks to their lives in general. One woman provided an eloquent example:

> *It all depends on what your ethics and morality is. Mine is that I don't burn people, I don't fuck with the drugs. The drugs I sell are the drugs I do. If I see that somebody is not handling their drugs, I will not sell to them! I may not tell them that I think they're not handling their drugs because if they aren't, they aren't going to listen to me anyway! But, it's easy for me to disappear from their venue for a while. More ethics and morality is that you don't talk about who you buy from, you don't talk about who you sell to. You do an honest and clean business. You don't fuck people up. You never sell people their first line! I expect the people that I buy from to be as honest as I am! (075)*

The issues of self-control and control over others are significantly interwoven especially among dealers. We found a significant difference related to the issue of control over one's life framing the context of methamphetamine dealing. For many women dealers this business enterprise gave them the power to leave and/or control their husbands/boyfriends, to choose their friends, to control their lifestyle, and to maximize their talents relative to their resources. In general they considered themselves realists who were **satisfied** with their lives. One woman dealer who prides herself on her ability to have control over her life stated:

> *It's my business, my rules! And don't argue with me about it! I get to choose who knows I sell speed. I'm healthier now than I was when I started. I think it's because I don't have any moral dilemma over my drug use. I do drugs for a reason which I have rationalized to myself. ...they are now part and parcel with the whole thing. (075)*

3. San Francisco Bay Area Dealer Characteristics

There were several distinct types of dealers in the San Francisco site. The first type were the long-term inner city users. These respondents sold methamphetamine as their major source, hustled for other dealers on the street, or sold to supplement their welfare checks and for personal use. They tended to have a history of heavy use, now often modified by lack of resources or age. But they are generally living in marginal social worlds for whom dealing has become a way of life. One woman who has been in and out of jail for prostitution, drugs and other crimes states, for example:

> *I do speed to stay up so I can sell speed to make money, but I sold speed to make money so I can buy more speed! (056)*

A 47 year old African American woman who began using 25 year ago and never really made the switch to cocaine. She now deals crack to get money for meth, because that's where the market is and,

> *[Crack] is more available, too. When I went to jail and they were booking me in, they said to me "You're a speed user? Is there still any of that around?" [laughs] It's all crack now! (149)*

Another type of methamphetamine dealer in this study also is found in the inner city area, particularly the South of Market area. These dealers cater to a wide spectrum--young, white, middle-class "party-time" club goers, musicians other "artists," prostitutes and hustlers (both gay and straight), trendy "deviants", and the long-standing drug addicts. The dealer described in these ethnographic notes, typifies the "new" independent business person in this neighborhood:

> *This is a dealer which uses quite heavily, but keeps herself together. She knows and gets along with all her customers, she in turn always gives fair weight and a high quality product. She prides herself on the fact that she would return low quality compounds to the source rather than sell it. She talked a lot about trust and friendship, and even though there was a lot of traffic, she said in the end she relies on her intuition. If she has doubts, she says no. This woman has been selling for five or six years, but for only four of those years primarily methamphetamine. (ethnographic note #26, 1993)*

> *I've done a few small sales, but, over the last 3 years, I've been dealing to 4 or 5 max, select old friends. People I know I can trust [knocks on wood] and I sell to them for their personal use. I don't sell to make money, just to support my habit. Sometimes in the past, I moved lbs. That was a couple years ago, 2 or 3 years. Last year I moved about 1 oz. (054)*

Another major type of dealer came from the East San Francisco Bay Communities, generally in Contra Costa and Alameda County. These tended to be full members of the lower-working class neighborhoods where they did business. There were a vast array of levels and types of dealers, from the speedster who barely got it together to buy the small amount needed to cover his use, to the more enterprising business person for whom dealing was his main source of income. In either case the business had to adapt to the unique features of the market in these areas. As one dealer illustrates a "typical" set up.

A week for me was 1/4 lb. It fluctuates, most people get paid every other week. I had so much shit that people brought me to trade, you wouldn't believe it! 15 TV's, kitchen shit, 10 water beds, I had all this stuff. Steady customers usually brought me shit. [But] you want the money to re-up...I had a little bit of everybody. Mostly people off the streets. They'd come to me with their welfare check! People that did landscaping, yard work. I had thieves that brought me shit. Sometimes, I'd keep it or sell the hot stuff. More trading. The white collar workers were harder to deal with. They were paranoid and I had to meet them in certain spots. They didn't want to be seen coming into my house! (021)

4. San Diego Area Dealer Characteristics

There are several ethnic and regional differences among respondents dealing in the San Diego area. Although almost all respondents report having engaged in some type of drug sales, Caucasians in East County similar to their counterparts up north were likely to engage in trade and barter. A major type of dealer were the welfare moms in San Diego. Their situation centered around selling enough for use while earning a little extra to get by:

Well, every one who uses is a dealer [in apartment complex]. I mean,not major dealer. But like myself, to make a few bucks you sell a little of what you earn. Basically, that's what it is. (249)

There are many young male dealers in the east county. Most sold part-time in order to pay for their own use. They rarely practiced dealing as a business, rather see as a quick way to make money, do lots of drugs, and have lots of sex with lots of women.

G. started dealing big time and all kinds of chaos started, all hell broke loose! This apartment: imagine the lighthouse down at the beach with the light going around signaling everybody, that's what this place was! He made it full blown open, anybody that wanted to come in and buy stuff, come on in! Doesn't matter what the amount, how much noise you make, doesn't matter what happens! I'm gonna make a lot of money and we're gonna have a damn good time! The last couple months, things started falling apart. He got this stuff that had orange rocks in it, it smelled really bad, everybody was getting fucked up. Everybody in the circle got weird.(208)

Customers getting weird on meth was a main reason why dealers do not say in the business for any length of time.

After that, he quit selling it. He couldn't hang anymore cause a lot of strange people were coming and buying the stuff. He was watching, his normal friends had become these total freaks. Just for the high, they'd do anything for the high.(204)

None of the meth dealers seemed to cut their meth enough to make it questionable of use. I think meth dealers worried that if they put a bunk product out, meth users were so crazy they would come back and kill them or something! (205)

This respondent also offered this wonderfully vivid portrait of an East County low-class dealer's house:

Usually they were dirt bags. They were people on the very fringe! They were people waiting to get busted! On the street I lived on, there were 3 dealers. I would have nothing to deal with. If I wanted crystal, I would never have gone to any of those. For one reason, it was on my street and my parents could have seen me go there and for another reason, they were just dirt bags! They were the ultimate scum of the earth! They attracted the worst elements of society, felonious thieves, people who would steal anything to get crystal. I've seen people steal bikes on the street and try to fence them for crystal. They'd bring in a lot of stolen vehicles, stolen stereos, stolen everything. These places were usually filthy. You could just pick them out. By going by. The weeds are growing 2 feet up around and the paint is peeling, the roof is off, broken bottles around, trash never gets taken out, the smell of dog shit permeates the air, the kids go without clothes, public fornication, stereos cranked as loud as a stereo could go with absolutely no sense of community. They don't give a shit who is next door to them, what they're doing, it's incredibly self centered. These dealing houses. They are not like a crack house from what I've heard, that's very secretive and behind closed doors. This is, they're paranoid but they're openly paranoid, it's all out in the open. It's a very ugly scene.(205)

The Latino sellers in San Diego had quite different characteristics. They tended to sell enough to cover their own use, and sell within a small circle of friends and relatives. Although most profit is used up with the drug, they tend to keep dealing for longer than their Anglo East County counterparts. Some of these small scale sellers operate sporadically

I wasn't your big time dealer, I would be like a 16th and sell a couple of quarters to make enough money to buy me another 16th and I'd keep the rest for me. Sometimes I'd buy an eight ball. (238)

Others maintain a regular modest business. A 23 year old man began selling while in his mid-teens. Since loosing his job to meth-related problems a number of years ago, he now sells more regularly, but still at a modest level. He averages about six 1/4 gram packets a day. When asked about increasing the business, he replied:

I try to scare new customers off! I do throw a little bit more on the scale I weigh, normally it would be like a 2.0 on the little scale, so I weigh like 2.5. For $20 you can't beat it! I know these people, they are my people. (248)

The common problem among this group of sellers was the tendency to use up all their profits, which led to a number of other problems as well.

Yeah, I ended up doing what I had to sell. And ended up owing people. I could get it fronted with no money at all. ...Because I would use it. Or I had to pay bills. The money that I had used to purchase it, it would usually, if I was to keep my sales going, I would usually have more to buy more amounts, but when I got into my sales, my profits, I would come up short or sometimes all together I wouldn't have enough money to buy it altogether. (238)

This problem also occurred among Latino respondents who were large scale dealers, especially if they were also IV users. This 39 year old latino began using and selling 22 years ago,

I started selling crystal and peanut butter crank. I sold grams then I started selling ounces then pounds. I used to sell about 40 pounds a week of that. The first 20 pounds, (unintelligible) So I start using it heavy. I started tooted it, then I started smoking it then I started shooting it. I could go to sleep on it, at first I couldn't sleep, fuck or eat on it. But then I got immune to it to where I got sleepy. So I always had it so I always used it. (249)

5. Honolulu Area Dealer Characteristics

We found several major types of dealers in the Honolulu site. One of the most common were Hotel Dealers. These were often Filipinos who had a direct supply source and dealt in ounces. According to one respondent:

He was Filipino, a local. Born and raised here. He was a Waialua boy. He was getting out of hand with the money, flashing his money and jewelry. ....I started calling him Mr. T. because his gold, his diamonds, he was really choke! He had chains on his neck that he'd wear like Mr. T. It got to the point that business was going so good for him that he was flashy! If you knew him and the work he did, you'd wonder where is he getting all his money? On every finger was a ring, a Rolex watch. ... He started dealing out of Aiea. He never stayed in an apartment more than 6 months. He'd lease a place and deal there and live there. He never brought the dealing home to his wife and family. He had a couple right-hand men who stayed with him. He had computers there, everything. He'd move it around every time he moved. (542)

In the heady months of easy availability and enthusiastic customers, such flashy behavior was not uncommon. Unfortunately for most of these Hotel Dealers, their success was short. In the example given above, this person also continued to work at a federal job at Pearl Harbor where he eventually attracted the wrong attention, and was busted.

Another type were Neighborhood Dealers. These were most often Native Hawaiian, Samoan or Filipino who began dealing to supplement the family income. They dealt from their homes, in what they at first thought was an easy way to make a little extra and have some smoke left over. Often these were former pakololo sellers who thought in the beginning that ice was going to be a lucrative substitute. Most of these Neighborhood Dealers tell sadly similar stories. They let the easy money and the drug get out of control, often they quit their legitimate jobs, and eventually began using up all their profits. By the time we interviewed them, many had been abandoned by wives and children and were currently homeless.

At first I knew nothing about dealing. My nephew showed my how. I got my own scale and started from there. He taught me and I perfected it in my own way. My 50 cents papers was bigger than anyone on the island! That's why I was a success ...At home. I was always the MAN. I had what they wanted. I was arrogant cause I knew I had what they wanted and I played games with them. Out in public, I was low key. (461)

For Neighborhood Dealer Types in Honolulu, the business is integrated into the family. At the end of the 1980s there were many of these dealers, and almost every local family in some communities had at least one member who dealt. This, in turn, created the illusion during this time that ice was just another type of "homegrown" dope, where its illegality could be overlooked in favor of making a little extra income.

In the beginning, I had confidence cause I was making money. I got shaked down twice and nothing happened. I was confident cause I was making so much money and I couldn't believe it! [The police] knocked on the door and my son answered and let them in. They saw scales on the counter and paraphernalia on the counter. They questioned me and my son and we denied that we were dealing. Then they left. (461)

Dealing provided them with immediate popularity, an enhanced self-image, and lifted them above the mundane and unrewarding lives of poverty and hard work. Many of these dealers describe the early days of the business with a sense of pride, especially around their children. This Neighborhood dealer, like others worked in partnership with his teen son.

I got the feeling when he was working, he was a big man. He brought people home from work to introduce them to me. My daughter was in high school and her friends were using and wanted to meet me. (461)

Eventually, however, all the good came to an end and left only the bad. His use increased to the point where he could not do business, where pride and confidence were replaced by compulsive use, then guilt and denial. He ended up losing the business, his wife, his home, and his children.

A similar story is told by a neighborhood "auntie" who began dealing almost immediately after her step-son introduced her to ice:

I didn't even have a pipe then! I didn't know where to get one. Sometimes I'd spend maybe $300 a day on ICE. Buying it and sharing it with them. When his supplier came over one day to my house and introduced himself to me, that's when I went into dealing. ..I liked the high. Also I went into dealing. So, in order to deal, I had to stay up. That meant that I'd have free smoke. That was my main purpose in dealing, to be able to smoke free, and make a little bit of money for myself. Then it got into more and more and more customers and more demands. It got to be crazy! A lot of people who know a dealer, they tend to sponge off the dealer or see what favors they can get. They wanted ice, food, everything from me! .People started taking advantage and I stopped dealing finally. Then all of my so called "good friends" seemed to become my enemies because I wasn't there ...to give them the dope that they wanted anymore. (449)

Another type of dealer found in our Honolulu sample were "Hustler Dealers" who include dealing ice into a larger repertoire of scams and illegal activities. These respondents of varied ethnicities led a very marginal existence and were often homeless. Some were sex workers and live and ply their trade in either the downtown or Waikiki areas. Almost no one in this group is making any money dealing ice. Rather, they are dealing primarily for stash and can barely keep up. A male respondent in Honolulu described this cycle:

I'm surviving by getting enough for me, I'm buying by the oz. and selling by the 1/2 gram or 1/4 gram. I'm dealing. I'm turning $1000 into $3000. I'm doing it once a week but I'm using also. I'm paying some of my bills, not all of them. I'm drinking hard. I'm buying everybody in the bar drinks! ...I couldn't keep it up anymore, then I got homeless. I put everything in storage and met a guy in a bar. He was the "hot-shot" kid, the biggest dealer in pomo in California! ...we opened up our own film distribution company: make

our own films, film at home, edit our own stuff and party. Fuck around, do all the things that we like to do! We got funding and a big house and played at the beach. I'm still dealing ice, I'd weigh it out ... and stay up. If something happened, I wouldn't miss it. I was feeling good about nothing and depressed. Everything at this point in time is false. I don't like anybody, I don't trust anybody. (453)

C. Dealing and Distribution Networks

1. San Francisco Bay Area

There seem to be numerous supply networks throughout the San Francisco Bay Area. In the East Bay communities there can be as little as one or two mid-level distributors between the cooks and the dealers. Very often, they have run a discreet business over an extended period of time, selling only to trusted customers. These east San Francisco Bay dealers gave these descriptions of their sources:

I only got from one person mostly. Still a friend to this day. He's been doing dope all his life. He likes to deal. He socializes a little bit. But he mostly likes to ride his motorcycle when he's wired. ...he's affiliated, knows a lot of bikers. Everybody around here knows him and likes him because he wasn't a dirty dope dealer. He's a good dealer and he had respect. He never burned anybody. (104)
You'd be surprised! I'm very picky. There's only a few that I trust. Some people will sell Ajax! Soap! Trustworthy people that I've dealt with, one or two are pretty normal! One good friend sells and started out clean but got carried away with it. Big money got to her and she started acting different. It got to her head, ...Another buddy of mine, he's pretty cautious, he keeps reality pretty close. Most of the time, the people are jumpy and edgy, if they do the drug, they can get crazy. My contacts are respectable people, not thieves or gangsters. Nobody you'd be afraid of.(031)

A similar situation is provided by a dealer from the punk-rock scene in San Francisco:

I get it from one or two places. I like to get it from one particular place and do business with that person more than anywhere else. I don't like to get it from the street. I stay with one person I can trust. ... After I dealt for so many years, I know who and where the stuff comes from. I'm fairly close to the source with my connection.(044)

A young woman dealer from the inner-city describes her source in the same manner:

I have one regular source where I get it from. It's a woman about 30 years old. She's okay. She's more like my friend. I'd go to her house and do a line. I bring her some pot and then we go out and do something. She's my best friend actually. I pay her and then I leave. I taste it sometimes to see how strong it is.(094)

According to some dealers, some distributors keep a tight rein on street dealers in order to keep the price inflated.

Rumors were all. If dealers aligned, you'd have a lot more money to deal! If you went in with another dealer, you could buy a lot more than he could alone. Being a dealer in New York used to be a real respected position! People watched out for you. Here, you're preyed upon by people who try to work you and rip you off for drugs and money. The snitches are involved actively in this process. (044)

Competition and betrayal were themes echoed by other dealers, including this 27 year old with 13 years of experience in the business

I've had suspicions about people putting my name and my business on the street. Because of the competition, they want me removed from the game! People that tried to drive me off before were paid informants and wanted nothing to do with other sellers except me! Other dealers have not liked me because I put a huge dent in their business! [with] Consistent good dope, best prices, least amount of cuts. No bullshit either. (054)

One very high level dealer/distributor with biker connections reported that the business dealings amongst other dealers were always dangerous and he carried weapons at all times. He states

You're constantly carrying guns. You're constantly walking around, looking over your shoulder. When we all met, out of courtesy to the house that we were in, we all set our weapons down on a table. I always carried two weapons, set one down on the table. I never let myself go into any place without having one. (069)

The need for caution, dictated the process of making large purchases from mid-level distributors, as seen in this example of the process:

Call, get verification that somebody will be there, call up people if I needed money. If I didn't have it all, I'd go collect money on the way. I have my scanner switched back a couple of times to see if anybody might be following me. ... Any car that I see in my rear view mirror I don't let tail me. When all the cars behind me are different, then I go cop. I do it usually in a public place, put the money in a real estate magazine. Swap money for dope out in the open.(054)

Labs in the East San Francisco Bay are do not fit one uniform type. Rather, they seem to be found, anywhere, and to be run by a number of different types of people. One dealer, for example, describes a lab which had manufactured quality product from a location in the heart of an African American community.

There was a period in 1991 where it was alright. But that only lasted until this lab got busted down here...The one down there off, by Eightball Trucking. Down by Color Spot, by the auto wreckers. ...Yeah, right there by the Christian Men's Home. [I:Holy cow! Right in the middle of North Richmond?] Where they should be making crack cocaine instead of methamphetamine! (104)

It's not as available as it used to be. There's not that many people dealing it as there used to be. The larger distributors are either in jail or too paranoid. The manufacturers are not readily available as they used to be. I guess because of the crack-down on drugs.(044)

I know her manufacturer, too. I don't go to him cause he wants to know me and he's really paranoid and dangerous! I don't want a relationship with him. He's a Mexican and I wouldn't ever know what was going to happen with him. ...I went over to his house once. He has a kid who is a year older than me and he wanted to go out with me! [laughs] What a dirty old man! He said he'd give me crank for free and all this, come and party with him! No way! He called me several times. But I didn't want to be seen at his house cause you never know who's going to walk thru the door or what's going to happen! When there's a lot of traffic at a place, that's risky! After I went to his house, cops started following me! Bullshit! He seemed like a nice guy, old but nice. ...I never saw any [cooking] equipment. I heard his stuff was underground and he made it inside a truck underground.(094)

One high-level dealer in the East San Francisco Bay area, asserts that he bought from all types of people, and makes references to "suits," businessmen who bankrolled the manufacture and distribution of methamphetamine because there was such a tremendous profit to be made.

As a matter of fact, a lot of the higher-up people, you'd be amazed at who they were! (069)

This was supported by another higher level dealer from a "blue collar" community in Western Contra Costa county who bought quarter pounds of meth from "white collar" business associates.

No, no they weren't but I had an unique position because I was, I'm a San Pablo white boy, but I'm not like other San Pablo white boys cause I could fit into any place where a typical SPWB would stand out like a sore thumb, and so I go to parties, I'm taking about parties like Orinda, Moraga, Blackhawk, and I not stand out. Buying dope from these people, I'd go over there, maybe have dinner with them, come home with a 1/4 pound, or I'd go to a, maybe they were having a party, and I'd go over there and they would introduce me to their brother-in-law or some family friends and small talk, this is in Blackhawk, most of his family knew what he was doing. Yeah, you see the larger the amounts that I was buying, was a guy that owned a company, that one of the companies I worked for did business with. Businessmen.(081)

2. San Diego

Much like the East San Francisco Bay Area, distribution networks in San Diego, especially in the East County, are reported to be plagued by mistrust and betrayals. Consequently, dealers selling in higher volume to lower-level sellers are very cautious and serious about how they conduct business.

In the deep, thick of things, I used to sell up to 1/4 lb. a weekend. A couple ounces to individual people. I got dope for the people who sold dope. On a regular basis, just so many every week and that was that! Some weeks were more, some less but I've lived a couple patterns. They have always been business-like. I get high with some of the people I sell to, they always treat it as a business and a privledge to be able to deal with someone who was punctual and did what they said! That I pride myself on!(293)

I control the people that I sell to. They get it for other people and I never see the people they sell it to. There's been people I've sold to and they have acted so badly, I cut them off instantly! They will get me busted by their behavior. I won't allow it. (297)

Distribution networks in Eastern San Diego County seem to be very diverse. There continues to be numerous small production enterprises. One cook also acted as the mid-level distributor to lower-level dealers. By separating his two roles he was able to protect himself and make a higher profit.

To them, I was doing small quantities. There is more money in smaller quantities. But, you create more traffic at your house. When I was dealing it on a daily basis, probably 15 people. Maybe 20 people. Normally, I didn't contact no one. Selling something you're making, you tend to label it and you don't want to be labeled as a cook. You'll get busted real fast! You're manufacturing, you're the one! You're the top of the totem pole, people want to take you down! (271)

Given these types of problems, many dealers spoke of constant disruptions in their network of suppliers, and problems with quality control.

People started to get greedy. You could buy 1/2 oz. or 1 oz. of really good, killer meth and the next time you went back to the same person, the quality is half cause the guy is getting greedy! But, those people usually ended up getting busted, too. People that got real greedy, they get pissed off, they get raided.(322)

According to some respondents, there was still some biker involvement with distribution and manufacture.

One guy that I know, once a month he drives up to Oakland and loads his van up with 20 to 30 lbs. of crystal and drives back to San Diego. Before he goes home, he stops at all these different places and drops off a certain quantity at each place. The people pay him the money directly plus he has a lot left over, to make either extra money or to have for himself to buy more. That's one of them. A lot of bikers hang out in Lakeside. They have little ranches tucked back in the hills and they cook out there.(289)

Most Latinos who dealt reported obtaining their product from whites, often stating that they knew of few Latino manufacturers or distributors.

The most people that I know that are hard-core producers and making it, they are all white men. Mostly all I deal with are the white people. (248)

There was evidence as well that there is a substantial amount of meth coming in from Mexico:

It's coming in every day. You don't drive thru the border checks, you walk across and you walk back thru. When you walk thru at Customs, they don't search your shit! They ask you if you have anything to declare and you say no. If you get in with a group of Mexicans, the Immigration people are looking at them cause they're waiting for them to dart out the door! So they pass you by.(289)

...the Mexican side of it. They don't let you get too involved, too knowledgeable into what they're doing. [Being Caucasian] and they have a totem pole system that you have to come up thru. I knew one guy who was selling crystal here and he'd cut some, 50/50, and have some about 90% pure, he'd offer you a choice. That's the way they work, real weird. (271)

3. Honolulu

In Honolulu the same family connections which characterized use patterns, also framed dealing enterprises in various communities. This was especially strong within Filipino dealer networks. One Filipino explained why he had no problem with other dealers.

I had my own traffic and they had theirs. ... I knew [the other dealers] where I was living, there was 4 or 5 of us dealing. We respected each other's traffic. You can tell who is a dealer by the gold chains, fancy clothes and the way you walked. They carry a beeper, too. The other dealers I knew, we were all related to each other. We was family. (461)

But dealer networks in Honolulu went far beyond these "family" groups. It was built upon a partnership between Hawaiians, Samoans and Filipinos which was structured to distribute the flow of ice from the Philippines into local communities on the island. Moreover, this ice network was built from established ties of brotherhood which had bound these groups together since the plantation era. A Filipino dealer outlined how this dealing partnership began, organized around "The Hawaiian Brothers" when ice first began flowing into the islands.

They had gatherings to advertise the ice. It was mostly Filipino immigrants who spoke bad English and you had to smoke ice. There was a leader, we called him the "Contributor" and he gave funding. He supports it with money. I've known the leader for a long time, he's back in jail, has no money but everybody goes to him. ... it started with a few guys and then it became bigger. Nationalities stick together, so everybody was solid at that time. The person at the top started advertising and using the Hawaiian Brothers got big. (523)

There are several respondent accounts of how these networks began to unravel as tensions and paranoia as ice use continued to increase within these communities. Eventually, a violent homicide fractured the network into smaller groups.

This guy shot somebody, so the flow of the drugs got slowed up. Everybody started breaking out into some small groups. Everybody was paranoid, it was a hard time to get some. I was holding on to a lot of shit when he got busted, in 1987, about 10 people were holding his stuff. (523)

One consequence was increasing competition for turf instead of cooperation among dealer networks. This required some action in order to maintain equitable market shares within the ice marketplace on Ohau.

I didn't stop using and I knew plenty guys in the Hawaiian syndicate...the local guys. They paid taxes to "Papa" and he used to take in about $200,000 a month. The "Waianae Connection" would make us pay taxes to them for certain things. It was territorial. The local guys used to rip off other dealers and they'd retaliate. [like paying protection?] Yes. This connection gave plenty benefits for dealing with him. That's basically how it is. (523)

According to this respondent, under this new structure Hawaiian and Filipino connections remain friendly.

Although most users and dealers claim that most ice is from the Philippines and Korea, opinion varies widely about the exact sources and distribution routes. Periodical large seizures of ice at the docks, or busts involving Korean or Japanese (Yakuza) gangsters reinforce this belief. Knowledge of where ice actually originates is limited to these news accounts for many Honolulu respondents. For example:

There was a real big, it was ironic, next door to us was an apartment building and the guy there got busted. It was the largest bust they had here. He had $10,000 cash in his car! He turned over on the Koreans. Our understanding was that ice was either coming from the Philippines or thru Korea. That's where this guy got it. Our people were mostly local who were middle men. We never went with any of the big guys. (518)

There were also many families involved with large Asian distribution rings which took several forms. Often getting established in these international enterprises, also relies on one's connection to family. A major distributor in Honolulu, became involved after seeing the advantages connected to his employment at the city harbor which offered a lot of potential. The key however was his coworkers who was also the brother of an international ice distributor.

When I was young and got the job at the Harbor, his brother used to run a ship with gambling and stuff. He's my friend. The trust was there. How we did it. It used to look like a family visit. I'd have my son and my old lady walk up with me. I'd come home with a shit load of stuff to take to people and sell. Some for me too. I was trusted. (521)

Both dealers and users from the downtown area often exist outside dealing networks. Dealers seem to compete more for customers, the traffic is not through established local connections. This where haole dealers most likely work, but downtown dealers come from various ethnic groups.

Um, most of my friends were local and most of them were Hawaiian/Samoan. But I know they got ice from Filipinos. We sometimes got it from a couple Black friends. (518)

One result was a high degree of variability concerning quality and purity. Sellers in the downtown area were also more likely to sell bogus product. One Haole male respondent worked mainly in the sex industry and lived in various hotel with his girlfriend who was also a prostitute. He claimed that as a haole he never got "good deals" on ice, and often got sold bogus product.

Purity is a big thing, you get a lot of crap! You have to be really careful. People sell styrofoam, shit like that! I can't imagine what shooting that will do to you! Probably nothing good! Yeah, we got a lot of crap. That's basically why we quit. It just got to be ridiculous. We were trying to screw each other over and playing games we promised we wouldn't play! (529)

We found, however, that mixed ethnic "locals" relying on downtown dealer networks had similar problems. One aftermath of the ice "goldrush" era is that countless numbers got on the dealing bandwagon in various ways. Many started making regular trips to the West Coast, buying meth at mainland prices, bringing it back, and attempting in various ways to turn it into ice and to turn a little profit at the same time. Consequently, fly-by-night temporary dealer networks sprang up in the hundreds, resulting in havoc all over the island with a saturated ice market and no quality control.

There are also a number of respondents who contradict official claims that ice is only imported from outside the islands. Several years ago, there were reports of small labs on Oahu.

One of our dealers had friends who got it direct from the manufacturer here. Most of them were, I know the Filipino group was more imported in, than some of the Korean was flown in. We had one, I don't know if she manufactured at her place or what, but that's where we got the best product. (518)

Another respondent with extensive dealing experience also made the link between Koreans and local manufacture.

...as far as I know, he was the only distributor. He had two other people above him, which was the person he was getting it from and the person he was getting it from was the cook. The stuff that we had, had it's own chemist. [The chemist was here in Hawaii?] ...I'd say, if he was here at one time, he only stayed for 3 months at the longest. He would move his laboratory every 3 or 4 months to a different location. (542)

Reports of homemade ice continue to increase, and several respondents talked about what they knew, or "didn't know." When asked if he knew if there were labs on the Island, he responded:

I never ask questions, no! I never cared to ask. I have no idea. I think a lot of it was synthetically produced. Sometimes there was such a difference in the taste. The stuff that was synthetic seemed to be more white. This is my assumption. It wasn't bitter, it had more of a vanilla extract taste to it. Yeah. It was more white. Where it came from, you don't ask questions like that because that will get you in BAD trouble! Physically, bad troubles! Yeah. You just consider everything you get manna from heaven! I know a lot of it was probably out in the country. Waimanalo-side, more than Waianae-side. I suspect a lot of it was [manufactured here] because there's Hawaiian housing out there and they're well protected. They're protector-owned out there, yeah. I strongly believe that.(527)

Considering the limited knowledge Honolulu ice users have about methamphetamine in general, it seems most likely that these reported "labs" are, in fact, meth in powder form which is brought in from the mainland and then turned into ice crystals by locals or recent haole arrivals in Hawaii.

E. Summary

The findings presented in this chapter on dealer characteristics reveal several commonalities and differences by gender and ethnicity and across study sites. Most dealers in all three sites come from lower class backgrounds, and sell meth primarily to be able to cover the costs of personal use. Most attempts to expand the business bring expansion of use and eventual loss of control over both. Women seem to be more successful at maintaining control over their lives, their use and the business.

Dealing and distribution networks in all three sites shared some common characteristics. Each area is comprised of myriad small-scale local distributors which cater to limited numbers of dealers/sellers. **"Trust and Turf"** seem to be twin concerns in each area, evidencing the shroud of fear which seems endemic in the California sites especially. Thus, some dealers in all sites had clear distinctions between "respectable" and "low-life" networks.

One of the major differences between dealer networks was based on how these networks formed. In Honolulu, they were often based on kinship or ethnic ties. In the eastern communities in both California sites, they were more likely based on geographic locale. This also determined the boundaries of "trust and turf" within which these network operated. Another major difference was in the source of supply between California sites and Honolulu. In California the source was often connected closely to local networks, while in Honolulu almost all ice is imported from the Far East through large-scale distributors.

CHAPTER X:

ANALYSIS AND SUMMARY

A. Introduction

A primary aim of this exploratory study was to: locate, examine, analyze and compare user types, environments and relationships involving methamphetamine use. These data were systematically discussed in the preceding chapters. Another important goal for this exploratory qualitative research, however, was to uncover contextual conceptual frameworks, to generate theoretical questions, and to suggest possible venues for future exploration. There are a great many theoretical issues which arise from the richness of these findings. This chapter offers a number of conceptual interpretations for major issues emerging from the data. The discussion provides a contextual analysis of the interrelationships between these issues. The final section of the chapter presents recommendations for future research derived from these analyses.

B. Disruptive and Abusive Family Backgrounds

A significant concern emerging from respondent interviews are the extensive reports of seriously dysfunctional family histories. Moreover, as discussed in Chapter Five, most of these include accounts of serious drug and alcohol problems, as well as physical and sexual abuse. The qualitative depth interviews, in following the life histories of our respondents, revealed the ways in which these childhood experiences shaped their later patterns of meth use, and the nature of negative consequences. Growing up within extremely stressful, abusive, and often violent family environments was the most commonly reported background history spread equally across study sites and user populations. Moreover, the types of experience were surprisingly similar, and often were interconnected.

The high proportion of respondents reporting parental alcohol and/or drug problems in Chapter Five described how it provided the setting for an entire range of abusive behaviors. The majority of respondents who grew up with a substance-abusing parent spoke of living under extremely stressful, and often dangerous, conditions. In Honolulu, especially, spouse and child abuse almost always accompanied a parent's heavy use of alcohol or drugs. Approximately one-third of the males stated that their fathers would beat their mothers after heavy drinking episodes, and that they, themselves, lived under harsh disciplinary rules enforced regularly by physical beatings.

Approximately 40 percent of the females in Honolulu described living in extraordinarily violent homes. Furthermore, about a third of our female respondents reported being physically abused by one or both parents, or sexually abused by their father or close male relative. The case notes of a 19 year old Hawaiian woman provides a good example:

> Her father routinely beat up her mother to the point where she could not walk. Her mother, would take out her anger and hostility by beating her and her siblings. Both parents were using drugs heavily, and her father was a drug dealer, and was sent to prison for hanging

a man on a fence and beating him to death while drunk. At 14, she was raped at a family event by an unknown teenage male. She isolated herself, taking 17 baths a day and cleaning the house. Her mother found out, but did not believe it was rape. Her mother punished her by hitting her on the head repeatedly, and eventually sent her to a home for troubled teens. (462)

The experience of another Honolulu female illustrates the option they take as girls and their powerlessness.

> Filipina Chinese, and the oldest of 9 children, she stated that her father sexually abused her from her earliest childhood memories until she ran away from home at 14, when she deliberately got pregnant, hoping her boyfriend's family would take her in so she could escape the sexual abuse from her father. They refused to take her in, and her mother adopted her baby. She re-entered school under threats from her father who told her that if she did not get A's, he would teach her how to give a good fuck and have her earn her keep by selling her to his friends. Although she did get straight A's, he did give her to his friends for sexual perks. (479)

Extremely abusive histories were also common among inner-city "outlaw" women users in both California sites described in Chapter Four. Their background experience usually included sexual molestation by a family member. Running away from sexual abuse was the most common reason given for beginning their life on the streets. Most had made this transition before age 18, and several left home permanently as young adolescents. Although more serious abuses were found among these respondents in Honolulu and downtown San Francisco, we found that the majority of respondents growing up in economically disenfranchised communities in all sites describe substance abuse, violence and sexual abuse as common experiences in their families and in their communities. We found that abusive family histories had a major impact on the future lives of our respondents. They tended to make one of two choices often connected to the type of abuse, their class background, and the nature of their home community.

We found abuse so pervasive in the childhood environments of poor and lower-class respondents that most grew up under the assumption that they had "normal" upbringings. This might have created a particular conflict. Although, they may not have felt stigmatized within their own community, they eventually realized other more affluent communities lived under different values and norms. Faced with this potential conflict, many respondents felt less marginalized and more secure remaining in their home environment, knowing as adults they were living in a "deviant" community. This was especially true among respondents in economically declining, and often more geographically isolated areas discussed in Chapter Four: El Cajon in the San Diego site, San Pablo in the San Francisco site, and Waianae in the Honolulu site.

Other respondents who grew up in seriously disruptive families, especially those from middle-class backgrounds and those who were sexually abused, were more stigmatized and traumatized. They tended to break away from their families and home environments. Escaping from abusive homes, most were faced with equally traumatic and stressful lives on the street. They tended to form tight social support networks drawn together by common abuse experiences and by similar needs and patterns of drug use. The "outlaw" users in downtown San Francisco described in Chapter Four are a good example. They too continued to live within "deviant" social worlds, but within support networks they created in order to feel less marginalized.

A trend common to the vast majority of these respondents was the tendency toward self-destructive behavior including heavy drinking and drug use beginning at very young ages. This is the population which accounts for the greatest proportion of serious negative consequences presented in Chapter Seven.

C. Meth As Medicine

A significant finding emerging from our interviews concerns the considerable therapeutic value ascribed to methamphetamine by many of our respondents, especially in the California sites. As discussed in Chapters Five and Six, methamphetamine seemed to be the ideal medicine for certain conditions or disorders commonly observed in our sample population. Although rarely prescribed in current medical practice, the data presented in Chapter Three reveal that not long ago, methamphetamine and other amphetamine compounds were highly regarded and extensively prescribed by medical doctors for a diverse array of mental and physical problems.

Thus, given this history it came as little surprise to find that many older respondents were introduced to one of these stimulants in the form of pharmaceutical pills which were either prescribed by their doctor or obtained from a friend or family member. A wide variety of these pills, in ample amounts, were easily available. A good illustration is provided by a 42 year-old woman respondent who described her early experience with several popular amphetamine compounds during the 1960s:

> *First way I got introduced to it was my doctor gave me this thing for cramps. He gave me something called Daprisal. All it was speed! Take one of these, no cramps, nothing! Go clean the house! I was chewing speed every day!... My [alcoholic] dad also had Dexedrine, little yellow pills in his drawer and I'd help myself. My dad called them "happy pills" for his hangovers. I was speeded constantly!... It started the speed thing and also Eskatrols, from a friend. All these timed-release pills, Dexamyl, we were never out of speed! That was when we did Obetrol. My friend worked in a doctors office. She helped herself to the samples. (217)*

Respondents often relied on methamphetamine for multiple reasons during that period, especially appetite suppression and relief for depression. Accustomed to easy access, they describe going through a "rude awakening" after strict controls went into effect in 1971. Although these users eventually found powder methamphetamine as a replacement "prescription," they found the quality usually inferior, and the people and places they bought from dramatically different.

Along with these long-time users, many respondents also found beneficial medical effects from illicit powder methamphetamine. Unlike users in the pharmaceutical pill era, they discovered it's medical benefits often by accident after their initial use.

The most frequently mentioned therapeutic rationales for using methamphetamine continue to be for weight loss and relief from depression. However, there were a number of surprising findings involving other medical concerns. As we discussed in Chapter Five, childhood Attention Deficit Hyperactive Disorder (ADHD) was described by a substantial proportion of our sample. Importantly most of these respondents believed that they still suffered from ADHD as adults. For example, approximately one-fourth of the respondents in San Francisco (somewhat less in the

other two sites) felt themselves to have been "hyperactive" as youth and most believed that they still were that way. This is seen in our discussion of findings in Chapter Five, where these respondents cited the calming effect of methamphetamine. The uncanny similarity in these perceived effects indicate support for an adult ADHD disorder.

Similar effects were reported by a smaller proportion of our sample with histories of asthma discussed in Chapter Five. One obvious connection is the stimulant properties present in most prescribed medication for this condition. Some respondents reported first using alcohol as their initial substitute for their prescription drugs. Many of these users stated that meth had a calming effect, some of whom also described themselves as hyperactive.

Our data suggests the possibility of a very strong connection between the perception of meth as medicine and a particular set of interwoven "dysfunctions." Specifically, we found that individuals with histories of asthma were also likely to report disruptive family background experiences, depression, and hyperactivity. Similarly, respondents with histories of psychotic disorders like schizophrenia are equally likely to report disruptive family background experiences, depression and hyperactivity (see Chapter Seven). Furthermore, for this group in particular, the perceived definition of the "therapeutic" benefits of methamphetamine expands to incorporate many other effects as psychological keys to living in "normal" society.

D. Meth Use in the Context of American Values

At approximately the same time as law enforcement began its efforts against the first illicit methamphetamine labs operating in the San Francisco Bay Area, the AMA Council on Drugs (1962) was finding little reason for serious concern associated with the 8-12 billion amphetamine pills produced annually. Edison (1971) noted this ironic juxtaposition between the extremes of condemnation and complacency in an editorial piece which appeared shortly before the imposition of strict production quotas called an abrupt end to the era of pharmaceutical excess. In contrast to the stereotypical introspective, amotivated "pothead," he outlined how the frequent reluctance of Western cultures to control (meth)amphetamine production stemmed from initial unrealistic expectations of the drug's positive attributes which typically culminates in crisis before regulatory response and overreaction. Initially, however, the image of the (meth)amphetamine user is linked to the most prized virtues and patriotic values. In fact, Edison (1971) argues that the user comprises:

> *[a] caricature of widely admired American traits: intense activity, efficiency, persistence and drive, and the desire to excel, to break records, and to move with even greater speed. These are admirable behavior patterns that are not easily relinquished, even when a drug is required to achieve them (Edison, 1971: 609).*

We found that although the perception of the methamphetamine user is no longer positive, those traits are still connected to the drug by our users. In Chapter Five, we see that every one of these "widely admired American traits" were reported by our respondents to important motivations for their early use of methamphetamine. The most commonly stated initial responses involved the drug's ability to improve endurance and function; that is, to accomplish tasks, to accomplish them quickly, efficiently and in greater numbers. They also reported increased confidence, intensity and enthusiasm.

Grinspoon and Hedblom (1975) provide a theoretical rationale for understanding how our society's social values match the qualities of this "All-American" drug. Underscoring just how ideal amphetamine seemed to be to the cultural mind set, they observe that, "Societies tend to sanction for social use those drugs whose psychopharmacological properties accord with their ideas of behavior and performance" (Grinspoon and Hedblom, 1975). Given that these traits are highly valued in the workplace, it becomes clear why so many of our respondents were introduced to methamphetamine on the job, often by their supervisors or employers.

In addition, we found Edison's (1971) assertion that the "unrealistic expectations" of the drug's attributes led to overconsumption then crisis on a societal level to be true on an individual level as well. For our respondents, their initial positive experiences led to unrealistic expectations and overuse, which in most cases, evolved into problematic binge patterns and serious consequences.

F. Methamphetamine and Social Class

The socio-economic status of the respondent had a significant impact on a range of interconnecting patterns, motives and consequences of use.

1. The Puzzle of Middle Class Use

The small numbers of middle class users among our respondents in each location has emerged as an important issue in this study. In trying to widen our sample to locate possible higher status users, we enlisted consultants and interviewers comfortable with all socio-economic levels, and pressed them to locate middle-class and/or controlled users. In previous studies of illicit drug use these types have been accessible and cooperative. The relatively small proportion of middle class users in this study suggest either abstention and/or secretiveness among this population. Responses to questions of middle-class use from the depth interviews suggested many possible explanations supporting either assumption. There was general agreement, however, towards the increasingly negative attitudes about meth over the past 20 years in this population.

One reason why middle class users turned away from meth use is because of its association with low class biker distribution networks. College students, businessmen and other professionals had few links to this social world, which also carried an extremely threatening and negative image. The transformations in the quality of drug itself constitute another possible reason for this retreat from use especially the perceived difficulty maintaining controlled use of substances of suspect quality. Professional careers also left little room for dealing with the consequences of use, especially the strong after effects. This could be the reason why powder cocaine remains the stimulant of choice among professionals or more middle-class users. It fits better into the demands and concerns found in this population. It is of shorter duration, has relatively predictable effects, and has less problematic aftereffects. In short, it is perceived as more controllable.

However, our findings also suggest that middle-class users do, in fact, exist but are extremely "hidden" in isolated user networks.

There's a lot of government workers, people with money that are maintaining, they get up and go to work every day! But, they're on crystal meth! There's a lot of people out there in the professional world and I don't know if anybody has really delved into that realm but, there's a lot of hard-core drug addicts out there that are professional people! They can maintain control and no one ever knows! Even today, other business owners in the area of where my business is located, no one has ever mentioned to me about drugs, they don't know! People don't know. (322)

The more educated middle-class respondents in our study, considered methamphetamine lower class drug, and spoke of measures they used to conceal their use among their non meth-using friends. One college-educated user from San Diego stated meth's reputation in the late 1970s was even lower than today.

Oh, well, doing crystal then it wasn't really very popular because most people recognized it, most people that were into it were real low life's! So it wasn't really socially acceptable thing to do. ... Most of my friends didn't want anything to do with people who did crystal or crank. ...Yeah, low life's, big time! I wouldn't really tell anybody I was doing it at all. I wasn't doing that much of it. That's when cocaine became real popular. Real cheap. I had another group of friends that got involved in that. (207)

An additional reason why middle-class users are difficult to enlist as respondents concerns the impact of the drug war. For the past ten years it has no longer been acceptable to be identified as the user of any illicit substance. Many quit their use as a result. Others give the impression they no longer use, but continue to maintain secure and small user networks. One consequence of using in this hidden context is the necessity of constant vigilance, which means that controlling use becomes a serious concern, and usually reduces amounts of use.

2. Working Class

Among respondents with lower-working class backgrounds, we found a number of strong common characteristics across all sites, user types, and ethnicities. One major commonality found among these users were strongly-held values of a "work ethic." Respondents defined a range of activities and motivations which were remarkably close to the basic "American values" described earlier by Edison (1971). Methamphetamine use, especially during the early stages, was widely perceived to improve their ability to function on the job. For many respondents across all sites, this increased ability was defined as attainment of a worthy goal. In other words, meth not only made tedious or strenuous jobs more enjoyable, it also made value the experience.

Importantly methamphetamine-enhanced activities outside the job environment were often self-validated by a "work ethic". One respondent replied that the extra hours each day of enhanced energy, activity and motivation, from methamphetamine gave him "an extra day of the week which did not belong to the boss." Meth use not only extended their capacity to engage in leisure time, it also produced a shift from a time when one "rested," into a time when it "increased their ability to function." Respondents continued to speak of "work ethic" even after their meth use began to impede their work performance, causing many to loose their jobs. Paradoxically, our evidence, presented in Chapter Six, suggests that the subjective meaning remained linked to this initial motivation, even though the their activities could no longer be

defined as productive. Sadly, "work ethics" often turned into "tweaking ethics" where "the ability to function" was trapped on a treadmill.

Another finding supporting the value of a "work ethnic" among these users was seen in the numerous times, respondents say they use the drug for recreation, but describe "functional" activities and attributions which seem to be contradictory. As shown in Chapters Five and Six, respondents in all sites talk about using it to clean house, do crafts or work on their cars in the context of enjoying being productive. Many are like one woman from San Diego, whose use centers around these types of activities, when it "helps her to be the person" she really is. Importantly, although the activity is task oriented, she considers the **reason** she uses as purely recreational. The explanation for this popular interpretation was literally that with methamphetamine "work" became recreation, especially when not under the control of the workplace.

3. Conceptual Issues on Class

These findings reveal that during the initial period of use, working class and middle class respondents share similar rationales for their use of meth. Both populations identify meth's ability to improve function, and both speak of similar "work ethic" values. As use progresses among users in group, those with higher status and economic resources are more likely to link the ability to function involves more than simple "activity" it also is tied to the ability to maintain self-control. Middle class users, having more to lose, tend to employ a more relentless pursuit of individual goals and aspirations, so they tend to keep engaging in the "activities" which define this value. Thus they were more able to quit or modify their use when necessary. They tended to describe control as the ability to retain their job position, status, career, and especially resources. Many middle-class users who had lost control over their meth use, had common histories of abusive family backgrounds.

The evolution of lower class use patterns was generally different. Although they continued to have the perception that meth increased their ability "to function," the activities, themselves, changed as use evolved into heavier often binging episodes. For a great many of these lower class respondnets, the ability to function focused increasingly on various types of "tweaking" behavior. However, they continued to need to engage in in even these forms of activity which helped them hold on to an illusionary "work ethic" value. Consequently, respondents with lives which offered little pleasure, saw meth as a way in which they could function and derive pleasure from daily life. It was an escape from the reality of drudgery, marginality, and non productivity while retaining an illusion of control and ability to function. Findings from the depth interview responses suggest that these respondents used meth not to **escape** reality in general, but over time their meth use became linked to their need to escape their own reality to **recreate** another. Within this recreated reality they continued to engage in activities which they defined as functioning, but without control.

As we discussed in Chapter Seven, the importance of staying in control was more true for women than men. Women were more likely to speak of control in terms of maintaining it, and more like to talk of losing control. Because women were generally in charge of households and children, it would seem natural for them to be more concerned. Analyses of depth interviews from both sexes on this issue reveal, that although women were significantly more likely to maintain control over their lives and their use, many were also more likely to hold on to the illusion of

control long after they lost it. Most of these were women with troubled histories of parental or spouse abuse.

Findings from this study reveal other similarities found in lower working-class users across study sites. We found, for example, that binging behavior may not be totally a function of methamphetamine, but may be linked to similar behavior patterns common in economically marginal groups. Poverty, itself, produces consumption behavior which often fits a binging pattern. Those without a steady or adequate source of income tend to become avid consumers whenever they have the means to do so. When we examine respondents in higher socio-economic positions with a steady and adequate income we see a greater tendency to use in a controlled pattern -- regardless of their level of use.

Another noteworthy similarities was found existing between lower-class communities in Honolulu and the Eastern San Francisco Bay Area. As we discussed in Chapter Five, East Bay communities included several generations of meth users which marking the boundaries and traditions which frame the identity of those communities. A very similar situation existed in Honolulu, but there the long standing traditional illicit substance was "pakalolo" (marijuana).

In every other way, however, the economic and environment characteristics of the social worlds described above were very similar. Both groups lived in communities outside the central city, both were lower working-class populations, and both were part of a drug culture spanning generations. Most importantly, in both communities these two drugs represented more than a commodity and more than a means of consciousness alteration. They were traditional forms and served symbolic as well as instrumental functions. Class may well be the bond which ties this similarity together, and can be seen, perhaps, in the almost identical methamphetamine binging patterns among these respondents.

F. The Unintended Consequences of Control Policies

The unintended consequences of legal actions appear to confound the intention to control methamphetamine proliferation. Findings from interviews of respondents with thirty or more years of use history suggest that the unintended consequences often become the dominant forces shaping methamphetamine availability.

1. The Perils of Powders

The vast quantities of amphetamine pumped out by pharmaceutical firms would have seemingly obviated the need for clandestine production until the imposition of strict quotas sharply reduced licit production in the early 1970s. For example, the removal of liquid methamphetamine ampules from the outpatient prescription market in 1963 was an insignificant dent in a pharmacopeia of hundreds of amphetamine options. However, for the injectors who had become accustomed to the purity of the product and its ease of administration, this event had a much more significant impact. According to interviews with respondents surviving from that era, this seemingly insignificant control effort created a demand for a new illicit enterprise--the illegal manufacturing of water-soluble powder methamphetamine. Law enforcement efforts to combat this new domestic industry evolved into a campaign to eliminate the increasing number of meth labs in the Bay Area and elsewhere.

As discussed in Chapter Three, by 1971, the medical profession had joined ranks with law enforcement to drastically reduce the demand and the supply of pharmaceutical pills which had flooded the market for years. The institution of stringent regulations to curb the production and medical prescriptions of pharmaceutical stimulants resulted in the virtual elimination of diverted pharmaceutical speed from the black-market, after the smuggling of pharmaceutical pills from Mexico was eventually stopped. In response to this reduction, clandestine labs mushroomed, and increased production of powder methamphetamine of uncontrolled standards and unreliable quality. These were organized through closed networks of outlaw biker clubs, a combination which only furthered the deviant notoriety of both the producer and the product. After law-enforcement clamped down on Bikers' clandestine manufacturing and distribution, the bikers went further underground. This had the effect of encouraging new and independent cooks and distribution networks to emerge, and "crank" became even less controlled and more toxic.

Wide-ranging efforts to cut off the availability of the essential chemicals for manufacturing P2P eventually succeeded. As a result, however, the ephedrine reduction process of cooking methamphetamine became widespread. This method has easier-to-buy precursors, and it is somewhat easier to make, thus encouraging the growth of many more small, local independent operations, thus expanding the variability of the product and widening the population of users further. By the mid 1980's crystal manufacturing and its use had exploded throughout California.

This illicitly produced powder methamphetamine of highly variable quality has become the only stimulant option among all types of users. The small fixed-dose stimulant tablets arguably possess much less problematic and abuse potential than that posed by the perils of illicitly made methamphetamine powders. In addition to the potential hazards posed by toxic by-products or adulterants, the uncertain potency typically fosters overuse to ensure desired effects from products of widely varying and unpredictable potency (Chesher, 1991). Perhaps most importantly, the once common and arguably safer, less abuse-prone oral route has been supplemented by high risk snorting, smoking and injection use with all of their reinforcing attributes: fast up-take and ritual behavior. This results in increasing and more serious problems among users which leads to intensification of control efforts. This vicious circle fuels further delegitimizes all stimulants and decreases the potential for any harm-reduction alternative.

Consequently, those who used pharmaceutical meth for a particular problem, like depression, face a situation similar to the moral arguments against opiates which continues to result in inadequate treatment for many chronic pain sufferers. As with heroin, proposals to permit the prescribing of methamphetamine in treating adult ADHD face opposition from those fearing its "dangerous" abuse potential. Although various stimulants have been shown to effectively substitute for each other in providing similar therapeutic effects, recent studies indicate that there appears to be a number of cases in which patient response is very specific to a single stimulant such as methamphetamine (Cole, Boling and Beake, 1993; Hallowell and Ratey, 1994; Piscopo, 1993). Thus, strict quotas drastically reduce both prescription and nonmedical availability of pharmaceutical stimulant compounds. This results in occasional shortages of pharmaceutical Ritalin and Dexedrine with adverse consequences for those suffering from narcolepsy or ADHD (Cooper, et al., 1993; Piscopo, 1993).

2. Ice and Marijuana

Although most other currently illicit drugs boast a respectable and legal past, marijuana

has weaker pedigree, and a more negative history than it deserves, given its minimal potential for harm. Moreover, successful periodic campaigns designed to eliminate this "evil" herb, serve to steer the user toward more dangerous substances. Grinspoon and Hedblom (1975) note what might have influenced American society in the 1930s to greet the arrival of amphetamines as medical marvels while simultaneously condemning the "killer weed":

> *While marijuana was being brought to the public's attention as a menace capable of wreaking great havoc, amphetamines were introduced and promoted as perhaps the earliest technology-derived drug to provide "better living through chemistry." Amphetamines were products of modern technology; they came from the laboratories of great corporations, and, in the days before the growth of consumer skepticism, this lent them legitimacy; unlike the dangerous foreign weed, they seemed to have reliable, safe, known properties. And, of course, they had the backing of medical authority (Grinspoon and Hedblom, 1975:289).*

Findings presented in Chapter Seven on the social consequences of ice in Honolulu demonstrated that the latest version of the American campaign against marijuana continues to have the same unfortunate consequences.

Among Pacific Islander groups pre-existing drug use practices set the stage for the introduction of ice into Hawaii. Earlier studies have documented the role of alcohol in relation to indigenous intoxicating beverages ('awa), the eradication of those traditional beverages, and the simultaneous promotion of western types of alcohol beverages, and institution of native specific alcohol control regulations (Keaulana and Whitney, 1990). On the surface, Native Hawaiians and other Asian Pacific Island residents in Hawaii accepted this substitution. However, there is a possibility that eradication of traditional alcoholic intoxicants was quietly replaced by pakololo grown by "local" residents in family yards and fields.

As government authorities began the campaign to eradicate marijuana in the 1980s, a smokable drug known as "batu" from the traditional home of Island Filipinos, began to be used in place of the increasingly rare and expensive pakololo. However, batu was not a traditional intoxicant like 'awa or pakololo, it was a stimulant. As our interview data demonstrate in Chapter Seven, its popularization and widespread use had a number of unintended and harmful consequences for individuals as well as whole communities. Although the prevalence of ice use is not decreasing, there is a growing awareness among users that this is a dangerous substance, and a common realization that it is a poor substitute for pakalolo.

G. HIV: High Risk Sex and IV Meth Use

As we discussed in Chapter Seven, the many of our respondents reported engaging in high risk sex activities due to their meth use. This was particularly true among gay and bi-sexual respondents, especially in San Francisco where meth as long been viewed as an adjunct to sex. This tends more to be the case among gay respondents in all three sites.

Moreover, in this study, we found that many of these high risk behaviors are crossing boundaries into other social worlds. In San Francisco, for example, the club and Rave scenes have become a nexus for a wide array of user types, ranging from straight suburban

heterosexuals to those in the fringe gay social worlds. These are central places for selling meth, and for trying new and potentially dangerous experiences.

The other major finding concerns the increasing diffusion of injection drug use in all three sites. It is moving into groups who previously shunned IV completely. Most notable are members of biker networks, and prisoners who tum to IV because of its more economical uptake. This is true even among prisoners in Honolulu. With it's fast uptake rush, and cost-effective aspects, injection is more frequently seen as an alternative. This raises serious concerns. For example, in Chapter Six we reveal how users rarely move back into a slower mode once they begin injecting. As we reported in Chapter Seven, most IV using respondents admit to engaging in needle sharing activities during their drug use career.

H. Summary

It is clear from the results of this study that methamphetamine is not only firmly entrenched in some communities but is continuing to spread into new areas and populations, especially in California. Importantly, although it is becoming an increasingly popular substance, it is doing so without a high media profile. Illicit methamphetamine production will likely undergo a significant increase because of the convergence of several related factors. First, there is growing population of marginalized working-class who are unskilled and relatively young from economically declining communities. The economic situation in these communities continues to worsen, encouraging entrance into the illicit methamphetamine manufacture and distribution industry. Second, indications are that this is likely to move into the heartland of the country, despite draconian drug control, as have marijuana, and cocaine in previous years.

All our results from the study in Honolulu indicate that ice has found a firm and equal status among other illicit drugs on the Island. After the initial well-publicized tidal wave of ample supply and popularity, the population of users began concentrating in poor disenfranchised "local" communities on lee and windward coasts, and among marginalized users in downtown and Waikiki. There continues to be numerous and very serious individual and social consequences which clearly illustrates the havoc ice use causes among poor and troubled users. The future does not look bright. We have every indication that greater amounts of less expensive meth from the mainland will be processed into ice in Honolulu, or on the mainland, leading to more competition with "Asian" sources, thus driving down prices and increasing the social disruption. Also, if increasing production of mainland methamphetamine promotes the importation of high quality "glass" into Honolulu, it will seriously increase the problem in both areas. A higher quality, much cheaper, and more available ice will increase consumption in Honolulu, and production on the mainland.

There are major and confounding issues involving poor and working class respondents. Because this group is poor, it faces many problems. so we don't know how much is caused purely by the use of drugs and how much is caused by their life situation. We do know that the use of methamphetamine exacerbates, if not creates, many significant problems. Disenfranchised communities, dysfunctional families and troubled individuals emerge as the most substantial

contributing preconditions in providing access, interest and predictably problematic involvement with methamphetamine. These research findings clearly show the ways methamphetamine is particularly seductive for the economically disadvantaged and for people with troubled backgrounds, with its ability to improve energy, self-image, alleviate depression, and illusion of control and function.

H. Recommendations

Unlike the growing controversy over the therapeutic potential of marijuana, the sharply decreased role of (meth)amphetamine in contemporary medicine has inspired surprisingly little debate. Nevertheless, our findings reveal the need for reassessment measuring the overall benefits and costs of restrictions on prescription methamphetamine to current attempts of self-medication for the same conditions. Recommendations for future research in this area include:

* Research able to focus particularly on the transition from pharmaceutical methamphetamine pills to powder methamphetamine use after criminalization. This would include an in-depth examination and tracking of the health related conditions for which individuals originally sought medical treatment;

* Studies which examine and measure the efficacy and therapeutic benefits of pharmaceutical meth used to treat the the major medical conditions described in this study compared with the efficacy and therapeutic benefits of methamphetamine substitutes now commonly used for the same medical conditions.

The current illicitmarket produces unmonitored use, resulting in destructive patterns of binging, risk taking behaviors, and other negative health and social consequences. As this study has shown, the effects of moderate to heavy methamphetamine use have been especially acute among users with troubled and economically disenfranchised backgrounds. It is not yet known, however, to what degree the source of the problem is found in the chemical properties of the drug, the illicitstatus of the drug, the mental health of the user, or the social economic environment. Better understanding is needed on the intersection of class, gender, and methamphetamine use.

* Systematic comparisons are needed of non-marginalized methamphetamine users with disenfranchised users to determine methamphetamine's differential effects and to analyze the "real meaning" and implications of the American "work ethic" among women and men in these socio-economic groups.

* A comparative analysis is essential to examine the similarities and differences in the role of methamphetamine and cocaine among working class and middle class users respectively. Little is known about the relative impact of a number of

functional, social, environmental, or other motivations for the choice of one stimulant over the other.

The problems associated with methamphetamine use must be understood within the larger policy discussions of harm reduction.

* Research is needed comparing users in the United States to those in countries using pure, high quality products, and in countries governed by a harm reduction drug control policy (such as The Netherlands or Australia, for example).

* Studies which can systematically clarify the connections between methamphetamine and substances with less harm potential like marijuana are essential. Although the common assumption is that marijuana is a gateway drug, our findings suggest, especially in Honolulu, that this is not necessarily the case. Hawaii provides an ideal site for a potential longitudinal community-based social epidemiological study. It would then be possible to address questions how issues of supply and demand affect the transition to other drugs, and the consequences of these transitions for the individual and the community.

Our findings present convincing evidence that frequent and heavy use of methamphetamine has seriously destructive physical and psychological consequences. There are other indications, supported in this study, that the problem has a great potential to increase in the near future. Yet, there is a serious lack of information available to substance abuse providers. Consequently, the tendency is to ignore or neglect the problem even in communities with large populations of users. Moreover, there are virtually no prevention or education efforts which target methamphetamine users, with the exception of San Diego and Honolulu. Yet our respondent data seem to indicate that appropriate prevention and intervention efforts have a positive effect. Consequently, our final recommendation is for the development and dissemination of data and information for agencies and program providers, and for promoting the development of prevention and intervention programs targeting methamphetamine users.

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APPENDIX A

DATA COLLECTION INSTRUMENTS

1. TARGET POPULATION: INTERVIEW GUIDE
2. SCREENING QUESTIONNAIRE
3. QUICK REFERENCE SHEET
4. QUALITATIVE INTERVIEW GUIDE
5. QUANTITATIVE QUESTIONNAIRE

TARGET POPULATION: INTERVIEW GUIDE

1. CATEGORIES OF METHAMPHETAMINE USERS:

   GENDER

   ETHNIC GROUP

   RACE

   CLASS

2. METHOD OF USE:

3. KNOWN SCENES:

4. SPECIFIC USER GROUPS: (eg. students - bikers -etc)

5. GEOGRAPHIC LOCATIONS:

ID# _____

10-29-91

SCREENING QUESTIONS

(INTERVIEWER: ASK FOLLOWING QUESTIONS BEFORE MAKING AN APPOINTMENT FOR INTERVIEW TO CONFIRM RESPONDENT ELIGIBILITY. TURN IN WITH COMPLETED INTERVIEW

1. AGE - How old are you?
(Respondent must be 18 years of age or older) _____

2. STIMULANT OF CHOICE - Over the past two years, what has been your favorite stimulant?

_____

Over the past two years, what stimulant have you used the most?

_____

(Respondent must answer methamphetamine or ice to both questions to be eligible)

3. RECENCY OF USE - When was the last time you used methamphetamine or ice?
(Respondent must have used at least once in the last 12 months)

_____ _____
mon year

4. AMOUNT OF USE - INTERVIEWER: probe to make sure respondent averaged at least half a gram of methamphetamine (including ice) per month over the last year or used a total of at least 12 grams over the last two years.

YES___ NO___

5. PRIMARY RESIDENCE - While using methamphetamine (including ice), did you live primarily in the Honolulu, San Diego, and/or the San Francisco Bay Area over the last two years?

YES___ NO___

QUICK REFERENCE SHEET ID#_____

DATE OF INTERVIEW:_____ INTERVIEWER:_____

circle area: SF BAY AREA SAN DIEGO AREA HAWAII AREA

fill in: DISTRICT/NEIGHBORHOOD/COMMUNITY:_____

SEX:_____ AGE:_____ ETHNICITY:_____ MARITAL STATUS:_____

SEXUAL PREFERENCE:_____

MAIN USER GROUP/SCENE RESPONDENT ASSOCIATES WITH:_____

CIRCLE STATUS: HIV: NOT TESTED - NEG - POS - UNKNOWN Diagnosed: AIDS - ARC

LICIT/ILLICIT OCCUPATION(S):_____

AVERAGE ANNUAL INCOME (from all souces):_____

CIRCLE TYPE OF RESIDENCE:

APT - HOUSE - MOTEL/HOTEL - RESIDENTIAL TREATMENT - JAIL/PRISON - HOMELESS

OTHER:_____

CIRCLE METHAMPHETAMINE STATUS:

USES NOW - IN TREATMENT - QUIT USE - SELLER - MFG

LENGTH OF TIME USED:_____ AVERAGE GRAMS PER MONTH LAST 12 MONTHS OF USE :_____

CIRCLE MAIN ROUTE OF ADMINISTRATION: - SHOOT - SMOKE - SNORT - ORAL

OTHER FREQUENTLY USED DRUGS (CURRENT):_____

CIRCLE APPARENT WEIGHT: - EMACIATED - THIN - AVERAGE - OVERWEIGHT - OBESE

PHYSICAL HEALTH, CIRCLE STATUS: GOOD - FAIR - POOR

MENTAL HEALTH, CIRCLE STATUS: GOOD - FAIR - POOR

ANY PRISON OR JAIL TIME? (MONTHS)_____ CONVICTED OF A FELONY? YES____ NO____

DESCRIBE CLOTHES AND GROOMING:_____

_____

VERACITY:_____

ATTITUDE OF RESPONDENT:_____

_____

2-7-92

ICE AND OTHER METHAMPHETAMINE USE: AN EXPLORATORY STUDY QUALITATIVE GUIDE

INSTRUCTIONS TO THE INTERVIEWER:

DO NOT READ FROM THIS GUIDE DURING THE INTERVIEW.

BE CONVERSATIONAL AND INFORMAL. START BY ASKING THE RESPONDENT TO GIVE YOU A BRIEF LIFE HISTORY, BEGINNING WITH HOME LIFE AS A CHILD AND ENDING WITH THE PRESENT. LET HIM/HER KNOW THAT YOUR FOCUS OF INTEREST IS HIS/HER METHAMPHETAMINE USE AND HOW IT FITS IN WITH HIS/HER LIFE.

LIFE HISTORY

In guiding the respondent through his/her life history, be sure to cover the following areas:

1) Demographics

   A) Family of Origin (ethnicity, birth order)

   B) Details about Childhood (parents, siblings)

   C) School Years

   D) Work/Career

   E) Current Relationship Situation:

      1) Marriage
      2) Children
      3) Sexual Preference and Partners
      4) AIDS Awareness and impact on sexual behavior and attitudes

   F) Current Living Situation (accommodation, lifestyle)

2) Health History

   A) Physical Health as a Child through Adulthood

   B) Major Illnesses, Operations, Hospitalizations

   C) Mental Health History

   D) Diagnosed Hyperactivity and Prescribed Stimulants (Ritalin, etc.)

3) Legal History

A) Illegal Activities

B) Arrests/Convictions

C) Jail/Prison Time

NON-METHAMPHETAMINE DRUG HISTORY

IN PARTICULAR, PROBE FOR DETAILS REGARDING USE OF STIMULANTS OTHER THAN METHAMPHETAMINE -- INCLUDING COCAINE AND OTHER FORMS OF LICIT AND ILLICIT "SPEED" (CONSULT "STIMULANT GUIDE" FOR CATEGORIES AND NAMES)

1) For Each Drug (Including Alcohol) Used, Ask About:

A) Initiation, Age First Used, Motivation.

B) Positive and Negative Qualities of Experience.

C) Changing Patterns of Use.

D) Methods of Use (Probe for I.V. Use/AIDS concerns).

E) Problems Associated with Use.

F) Reasons for Quitting Use (Including Treatment).

METHAMPHETAMINE HISTORY

1) INITIATION OF METHAMPHETAMINE USE

A) Describe the circumstances surrounding your first experience(s) (overall set and setting).

1) Provide year and age of first use.

2) Describe motivation and expectations.

3) Describe method and amount used.

B) Describe what activities you engaged in during first experience (partying, studying, work, athletics, etc.).

C) Describe how you felt both during and after your first experience(s).

2) CONTINUATION OF USE (For the following, proceed in a roughly chronological order leading up to most recent use)

A) Describe how your use changed over time (including frequency and amount).

1) Describe different methods of use tried in chronological order and compare them.

2) Describe reasons for primary method of use and how this has affected frequency and amount of use.

3) What have you heard about ICE?

4) What have you heard about IV Use?

5) Of those methods you haven't tried, why haven't you tried them? (ASK ABOUT EACH).

B) Describe how your motives or expectations regarding use may have changed over time.

C) Describe what you most like and dislike about methamphetamine.

D) Describe what you feel to be the advantages and disadvantages of methamphetamine when compared with other stimulants you have used (particularly cocaine and other forms of "speed").

E) Describe what you most enjoy doing while high on methamphetamine.

F) Describe your Typical Methamphetamine Experience(s).

1) Describe where, when, how and who you typically use(d) with.

2) Describe quantity and street value of amount typically used.

3) Describe activities you typically engage(d) in and how methamphetamine has affected your functioning in them.

4) Describe overall experience including both positive and negative feelings associated with getting high from beginning to end.

5) Describe other drugs often combined with meth while high and how they affect the experience.

6) Describe the typical experience of coming down (including feelings).

7) Describe strategies employed to soften or counteract coming down. (Probe for use of other drugs both during and after the comedown).

(INTERVIEWER: IF RESPONDENT HAS EVER SMOKED ICE OR SHOT METH, REFER TO LAST PAGE FOR SUPPLEMENTAL QUESTIONS)

G) Describe effect of meth use on other drug use (and vice versa).

H) Describe any rules you have about using methamphetamine.

I) Describe any periods when you felt your use was out of control and how you dealt with this (including present).

J) Describe any periods when you didn't use and why (including attempts to quit with or without treatment).

K) Do you feel it is possible (for you or anyone) to use methamphetamine in a safe and controlled manner?

1) If no, Why?

2) If yes, describe How (include personal examples, if possible).

L) Describe any instances where you feel your use may have been associated with accidents, violent behavior or criminal acts.

M) FOR FEMALE RESPONDENTS: Describe levels of use, if any, during pregnancy or nursing and perceived effect on offspring.

INTERVIEWER:

For the following questions, have respondent first provide a general response that includes both positive and negative effects of meth use on each area of concern. Then probe for additional responses to each question, if necessary.

N) Describe how your use has affected JOB/SCHOOL performance and finances.

O) Describe how your use has affected your SEX life (Probe for changes in frequency and types of sexual activity, inhibitory and disinhibitory effects).

P) Describe how your use has affected your PHYSICAL HEALTH

(Probe for illnesses, energy level, nutrition, weight loss, memory).

Q) Describe how your use has affected your MENTAL HEALTH (Probe for both acute and chronic effects on confidence, self-esteem, emotional difficulties, depression, anxiety, irritability, violent behavior).

3) INTERPERSONAL AND SELF IMAGE

INTERVIEWER:

Probe for both men and women - pay particular attention to women's concerns about self image and relationships.

A) Describe how your use has affected your SOCIAL LIFE (Probe for effects on socializing at parties and gatherings as well as relationships with family, friends and co-workers).

B) What, if any, is the connection between your initial motivation to use methamphetamine/ice and your relationship to your partner (Spouse or lover) at the time?

1) in continuing to use?
2) in your pattern of use?

C) In what way(s) do you think that methamphetamine /ice improved your past or present relationships with your partners?

D) In what way(s) do you think that methamphetamine /ice harmed your past or present relationships with your partners (physically and/or emotionally)?

E) How has your use of methamphetamine/ice affected your self image (especially body image and sexuality)? How has it changed over the course of using?

4) OBTAINING/BUYING METHAMPHETAMINE

A) Describe amounts you have generally bought or received (both in weight and street value).

B) Describe how price and purity has changed over time.

C) Describe difficulty in obtaining methamphetamine over time (including current availability).

D) Describe different sources for obtaining methamphetamine and your perceptions of them (NO NAMES).

5) IF METHAMPHETAMINE DEALER AND/OR MANUFACTURER, ASK:
(IF NOT, SKIP TO #6)

A) Describe typical amounts you sell by one transaction and by month or year if applicable (including prices for varying quantities).

B) Describe amounts and cost of what you typically purchase or manufacture.

C) Describe changes in cost and purity over time.

D) Describe other sellers/manufacturers you personally know in the business (NO NAMES).

E) Describe your strategies regarding purchases and sales.

F) Describe a typical deal--From purchase to final sale.

G) If a manufacturer, describe purchase of precursors, equipment used and process.

H) Describe problems associated with selling and/or manufacturing. After asking for general response, ask about the following:

1) Problems associated with personal level of drug use
2) Monetary difficulties (e.g. getting money together for buys)
3) Police/Legal problems
4) Problems with clientele/buyers
5) Problems with other drug sellers/manufacturers

6) FUTURE

A) What do you think your future methamphetamine use will be like and why?

B) What do you think your future use of other drugs (including alcohol) will be like and why?

C) What do you think your life will be like in the future?

D) Do you have any specific plans for the future?

SUPPLEMENTAL ICE AND I.V. QUESTIONS

IF NOT FULLY ADDRESSED FOR ICE SMOKERS, ASK THE FOLLOWING QUESTIONS:

FOR ICE SMOKERS

1. When did you hear about ice and from what source(s)?

2. Why did you decide to try smoking ice?

3. Describe the process, equipment and techniques involved in smoking ice.

4. Describe the dangers/problems associated with smoking ice.

5. If smoking ice is not your primary method of use, compare it with your usual method.

IF NOT FULLY ADDRESSED FOR I.V. USERS, ASK THE FOLLOWING QUESTIONS:

FOR I.V. USERS

1. Why did you decide to try shooting methamphetamine?

2. Describe the process, equipment and techniques involved with I.V. use.

3. Describe dangers/problems associated with shooting methamphetamine.

4. If shooting methamphetamine is not your primary method of use, compare it with your usual method.

2-7-92

ICE AND OTHER METHAMPHETAMINE USE: AN EXPLORATORY STUDY
QUALITATIVE GUIDE

INSTRUCTIONS TO THE INTERVIEWER:

DO NOT READ FROM THIS GUIDE DURING THE INTERVIEW.

BE CONVERSATIONAL AND INFORMAL. START BY ASKING THE RESPONDENT TO GIVE YOU A BRIEF LIFE HISTORY, BEGINNING WITH HOME LIFE AS A CHILD AND ENDING WITH THE PRESENT. LET HIM/HER KNOW THAT YOUR FOCUS OF INTEREST IS HIS/HER METHAMPHETAMINE USE AND HOW IT FITS IN WITH HIS/HER LIFE.

LIFE HISTORY

In guiding the respondent through his/her life history, be sure to cover the following areas:

1) Demographics

   A) Family of Origin (ethnicity, birth order)

   B) Details about Childhood (parents, siblings)

   C) School Years

   D) Work/Career

   E) Current Relationship Situation:

      1) Marriage
      2) Children
      3) Sexual Preference and Partners
      4) AIDS Awareness and impact on sexual behavior and attitudes

   F) Current Living Situation (accommodation, lifestyle)

2) Health History

   A) Physical Health as a Child through Adulthood

   B) Major Illnesses, Operations, Hospitalizations

   C) Mental Health History

   D) Diagnosed Hyperactivity and Prescribed Stimulants (Ritalin, etc.)

3) Legal History

A) Illegal Activities

B) Arrests/Convictions

C) Jail/Prison Time

NON-METHAMPHETAMINE DRUG HISTORY

IN PARTICULAR, PROBE FOR DETAILS REGARDING USE OF STIMULANTS OTHER THAN METHAMPHETAMINE -- INCLUDING COCAINE AND OTHER FORMS OF LICIT AND ILLICIT "SPEED" (CONSULT "STIMULANT GUIDE" FOR CATEGORIES AND NAMES)

1) For Each Drug (Including Alcohol) Used, Ask About:

A) Initiation, Age First Used, Motivation.

B) Positive and Negative Qualities of Experience.

C) Changing Patterns of Use.

D) Methods of Use (Probe for I.V. Use/AIDS concerns).

E) Problems Associated with Use.

F) Reasons for Quitting Use (Including Treatment).

METHAMPHETAMINE HISTORY

1) INITIATION OF METHAMPHETAMINE USE

A) Describe the circumstances surrounding your first experience(s) (overall set and setting).

1) Provide year and age of first use.

2) Describe motivation and expectations.

3) Describe method and amount used.

B) Describe what activities you engaged in during first experience (partying, studying, work, athletics, etc.).

C) Describe how you felt both during and after your first experience(s).

2) CONTINUATION OF USE (For the following, proceed in a roughly chronological order leading up to most recent use)

A) Describe how your use changed over time (including frequency and amount).

1) Describe different methods of use tried in chronological order and compare them.

2) Describe reasons for primary method of use and how this has affected frequency and amount of use.

3) What have you heard about ICE?

4) What have you heard about IV Use?

5) Of those methods you haven't tried, why haven't you tried them? (ASK ABOUT EACH).

B) Describe how your motives or expectations regarding use may have changed over time.

C) Describe what you most like and dislike about methamphetamine.

D) Describe what you feel to be the advantages and disadvantages of methamphetamine when compared with other stimulants you have used (particularly cocaine and other forms of "speed").

E) Describe what you most enjoy doing while high on methamphetamine.

F) Describe your Typical Methamphetamine Experience(s).

1) Describe where, when, how and who you typically use(d) with.

2) Describe quantity and street value of amount typically used.

3) Describe activities you typically engage(d) in and how methamphetamine has affected your functioning in them.

4) Describe overall experience including both positive and negative feelings associated with getting high from beginning to end.

5) Describe other drugs often combined with meth while high and how they affect the experience.

6) Describe the typical experience of coming down (including feelings).

7) Describe strategies employed to soften or counteract coming down. (Probe for use of other drugs both during and after the comedown).

(INTERVIEWER: IF RESPONDENT HAS EVER SMOKED ICE OR SHOT METH, REFER TO LAST PAGE FOR SUPPLEMENTAL QUESTIONS)

G) Describe effect of meth use on other drug use (and vice versa).

H) Describe any rules you have about using methamphetamine.

I) Describe any periods when you felt your use was out of control and how you dealt with this (including present).

J) Describe any periods when you didn't use and why (including attempts to quit with or without treatment).

K) Do you feel it is possible (for you or anyone) to use methamphetamine in a safe and controlled manner?

1) If no, Why?

2) If yes, describe How (include personal examples, if possible).

L) Describe any instances where you feel your use may have been associated with accidents, violent behavior or criminal acts.

M) FOR FEMALE RESPONDENTS: Describe levels of use, if any, during pregnancy or nursing and perceived effect on offspring.

INTERVIEWER:

For the following questions, have respondent first provide a general response that includes both positive and negative effects of meth use on each area of concern. Then probe for additional responses to each question, if necessary.

N) Describe how your use has affected JOB/SCHOOL performance and finances.

O) Describe how your use has affected your SEX life (Probe for changes in frequency and types of sexual activity, inhibitory and disinhibitory effects).

P) Describe how your use has affected your PHYSICAL HEALTH

(Probe for illnesses, energy level, nutrition, weight loss, memory).

Q) Describe how your use has affected your MENTAL HEALTH (Probe for both acute and chronic effects on confidence, self-esteem, emotional difficulties, depression, anxiety, irritability, violent behavior).

3) INTERPERSONAL AND SELF IMAGE

INTERVIEWER:

Probe for both men and women - pay particular attention to women's concerns about self image and relationships.

A) Describe how your use has affected your SOCIAL LIFE (Probe for effects on socializing at parties and gatherings as well as relationships with family, friends and co-workers).

B) What, if any, is the connection between your initial motivation to use methamphetamine/ice and your relationship to your partner (Spouse or lover) at the time?

1) in continuing to use?
2) in your pattern of use?

C) In what way(s) do you think that methamphetamine /ice improved your past or present relationships with your partners?

D) In what way(s) do you think that methamphetamine /ice harmed your past or present relationships with your partners (physically and/or emotionally)?

E) How has your use of methamphetamine/ice affected your self image (especially body image and sexuality)? How has it changed over the course of using?

4) OBTAINING/BUYING METHAMPHETAMINE

A) Describe amounts you have generally bought or received (both in weight and street value).

B) Describe how price and purity has changed over time.

C) Describe difficulty in obtaining methamphetamine over time (including current availability).

D) Describe different sources for obtaining methamphetamine and your perceptions of them (NO NAMES).

5) IF METHAMPHETAMINE DEALER AND/OR MANUFACTURER, ASK:
(IF NOT, SKIP TO #6)

A) Describe typical amounts you sell by one transaction and by month or year if applicable (including prices for varying quantities).

B) Describe amounts and cost of what you typically purchase or manufacture.

C) Describe changes in cost and purity over time.

D) Describe other sellers/manufacturers you personally know in the business (NO NAMES).

E) Describe your strategies regarding purchases and sales.

F) Describe a typical deal--From purchase to final sale.

G) If a manufacturer, describe purchase of precursors, equipment used and process.

H) Describe problems associated with selling and/or manufacturing. After asking for general response, ask about the following:

1) Problems associated with personal level of drug use
2) Monetary difficulties (e.g. getting money together for buys)
3) Police/Legal problems
4) Problems with clientele/buyers
5) Problems with other drug sellers/manufacturers

6) FUTURE

A) What do you think your future methamphetamine use will be like and why?

B) What do you think your future use of other drugs (including alcohol) will be like and why?

C) What do you think your life will be like in the future?

D) Do you have any specific plans for the future?

SUPPLEMENTAL ICE AND I.V. QUESTIONS

IF NOT FULLY ADDRESSED FOR ICE SMOKERS, ASK THE FOLLOWING QUESTIONS:

FOR ICE SMOKERS

1. When did you hear about ice and from what source(s)?

2. Why did you decide to try smoking ice?

3. Describe the process, equipment and techniques involved in smoking ice.

4. Describe the dangers/problems associated with smoking ice.

5. If smoking ice is not your primary method of use, compare it with your usual method.

IF NOT FULLY ADDRESSED FOR I.V. USERS, ASK THE FOLLOWING QUESTIONS:

FOR I.V. USERS

1. Why did you decide to try shooting methamphetamine?

2. Describe the process, equipment and techniques involved with I.V. use.

3. Describe dangers/problems associated with shooting methamphetamine.

4. If shooting methamphetamine is not your primary method of use, compare it with your usual method.

3-12-92

OF TAPES _____

ICE AND OTHER METHAMPHETAMINE USE: AN EXPLORATORY STUDY
Quantitative Questionnaire

ERAL CODING INSTRUCTIONS:
R ANY COMBINATION OF 8'S (88 OR 888, etc.) = No Answer
R ANY COMBINATION OF 9'S (99 or 999, etc.) = Does Not Apply

CASE # BEGIN CARD #: ___ ___ ___
1 2 3

Date of Interview V104 ___ ___ ___ ___ ___ ___
4 5 6 7 8
mon day y

Gender 0 = Man 1= Woman V110 ___
1

What year were you born? V111 ___ ___ ___ ___
11 12 13 1

Which of the following was your primary residence while using methamphetamine over the last two years?

1. San Francisco Bay Area 2. San Diego Area 3. Honolulu Area V115 ___
1

Where did you live the major part of your youth, up to your 18th birthday?

CODES:

1. San Francisco Bay Area (within 7 counties)
2. San Diego Area
3. Los Angeles Area
4. Other California
5. Hawaii
6. Other U.S.A.(excluding CA & HI)
7. Outside U.S.A.

V116 ___

Who did you live with the <u>most</u> up to your 18th birthday?
INTERVIEWER: (PUT IN ORDER OF LONGEST TIME)

1. Mother and Father
2. One Parent Only
3. Parent & Stepparent
4. Other relatives
5. Foster Homes
6. Institutions (orphanage, juvenile facilities, etc.)
7. Other (SPECIFY)_____

1st Mention V117 ___

2nd Mention V118 _

7. What type of work did your father do <u>most</u> when he worked?

_____

_____

TO BE CODED LATER V119 _
1

8. What type of work did your mother do <u>most</u> when she worked?

_____

TO BE CODED LATER V120 _

9. What is <u>your</u> ethnicity? **(INTERVIEWER, IN ORDER OF PERCENTAGE)**
INTERVIEWER: SEE INSTRUCTIONS ON OVERLEAF

A: _____

B: _____

C: _____

TO BE CODED LATER V121 ___
21 2

10. What is your current religious belief and/or practice?

CODES:

01. Catholic
02. Fundamentalist Protestant (Baptist, Pentecostal, 7th Day Adventist, etc.)
03. Mainstream Protestant (Baptist, Methodist, Presbyterian, Episcopalian, Lutheran, etc.)
04. Mormon
05. Jewish
06. Eastern Religion (Buddhism, Shinto, Hindu, etc.)

07. Other (Specify) _____
08. None

V123 ___
23 24

11. How many years of school have you completed? V125 ___
25 26

hat has been your main way of making money (legal or illegal)
ver the last five years?
INTERVIEWER: LIST TOP TWO SOURCES OF INCOME IN ORDER)

_____

_____
TO BE CODED LATER

1st Mention V127 ___ ___ (27 28)

2nd Mention V129 ___ ___ (29 30)

low long have you done this in your life? (CODE IN MONTHS) V131 ___ ___ ___ (31 32 33)

In the last 12 months, how many hours did you work in this occupation in an average week? V134 ___ ___ (34 35)

From all legal and illegal sources, (including government aid & family) how much money did you receive in the past 12 months?

01 = $0 - $5,000 02 = $5,000 - $10,000
03 = $10,000 - $15,000 04 = $15,000 - $20,000
05 = $20,000 - $25,000 06 = $25,000 - $30,000
07 = $30,000 - $35,000 08 = $35,000 - $40,000
09 = $40,000 - $45,000 10 = $45,000 - $50,000
11 = $50,000+

V136 ___ ___ (36 37)

In the last 12 months, what has been your primary source of financial support?

_____
TO BE CODED LATER

V138 ___ ___ (38 39)

What is your current marital status?

1 = married 2 = divorced 3 = separated 4 = widowed
5 = never married

V140 ___ (40)

Do you have any children?

0 = NO 1 = YES
(IF NO, SKIP TO QUESTION #21)

V141 ___ (41)

). IF YES: How many? V142 ___ ___ (42 43)

). How many are living with you? V144 ___ ___ (44 45)

.. What type of housing do you currently live in?

CODES:
01. Apartment
02. House
03. Motel/Hotel
04. Residential Treatment
05. Jail
06. Homeless

07. Other:_____ V146 ___ ___ (46 47)

. Who do you currently live with?

CODES:
01. alone
02. with spouse/lover
03. with spouse/lover and children
04. with children only
05. with children and others
06. with parents or other relatives
07. with friends/roommates

08. Other: (Specify)_____ V148 ___ ___ (48 49)

. Have you ever been in the Armed Forces?
0 = NO 1 = YES
(IF NO, SKIP TO #26) V150 ___ (50)

. IF YES: How many months? V151 ___ ___ ___ (51 52 53)

. Are you currently in the Armed Forces?
0 = NO 1 = YES V154 ___ (54)

s one or more of your parents or other primary caregivers
ver used any of the following?

CODES: 0 = NO 1 = YES 2 = DON'T KNOW

Alcohol?.....V155 ___ 55

Marijuana?..... V156 ___ 56

Speed or meth? (Whether prescribed or not)..... V157 ___ 57

Cocaine?.....V158 ___ 58

Heroin?.....V159 ___ 59

Other illegal drugs?_____V160 ___ 60

las one or more of your parents or other primary caregivers
iad a problem with any of the following?

CODES: 0 = NO 1 = YES 2 = DON'T KNOW

Alcohol?.....V161 ___ 61

Marijuana?..... V162 ___ 62

Speed or meth? (prescribed or not).....V163 ___ 63

Cocaine?.....V164 ___ 64

Heroin?.....V165 ___ 65

Other (Specify)_____V166 ___ 66

Other (Specify)_____ V167 ___ 67

METHAMPHETAMINE USE

28. Which of the following methods have you used to take methamphetamine? (READ LIST)

CODES: 0 = NO 1 = YES

1. Snort?.....V168 _

2. Inject?.....V169 _

3. Smoke?.....V170 _

4. Swallow?.....V171 _

5. Other (Specify)_____ V172 _

29. Which method have you used the most overall?

CODES: 1=SNORT 2=INJECT 3=SMOKE 4=SWALLOW 5=OTHER V173 _

30. Which method was the primary one in your most recent period of use? (SAME CODES AS #29) V174 _

(FOR THOSE WHO HAVE ONLY SMOKED ICE, SKIP TO QUESTION #43)

1. What year did you first try methamphetamine? V175 ___ ___ ___ _
75 76 77

END CARD# 1 0
79 80

BEGIN CARD #

CASE NUMBER ___ ___ ___
1 2 3

2. At your peak period of methamphetamine use, how much do you, estimate you yourself were/are using in a typical week? (INTERVIEWER: GRAMS AND PARTS OF GRAMS) V204 ___ ___ . ___ _
4 5 6 7

n this peak period, what was/is the street value of the
ethamphetamine you, used in a typical week?
INTERVIEWER: CODE IN DOLLARS) V208 ___ ___ ___ ___
8 9 10 11

hat is the total number of weeks you used
pproximately that amount?
INTERVIEWER: THESE WEEKS NEED NOT BE CONSECUTIVE)
V212 ___ ___ ___
12 13 14

hat is/was the most methamphetamine you have ever
sed yourself in one day?
NTERVIEWER: EMPHASIZE RESPONDENT'S USE ONLY
(GRAMS AND PARTS OF GRAMS) V215 ___ . ___ ___
15 16 17

low many days ago was your most recent use of
ethamphetamine?
IF USED ON DATE OF INTERVIEW, CODE 000) V218 ___ ___ ___
18 19 20

uring the last 12 month period that you used methamphetamine,
ow many months did you use at least once? V221 ___ ___
21 22

n an average month of that 12 month period, how many
ays did you use? V223 ___ ___
23 24

n an average month of that 12 month period, how many
rams did you, yourself, use?
GRAMS AND PARTS OF GRAMS) V225 ___ ___ . ___ ___
25 26 27 28

uring that 12 month period, typically how many days
(in a row) without sleeping did you use? V229 ___ ___
29 30

hat was the longest episode in days that you used (in a row)
ithout sleeping during that 12 month period? V231 ___ ___
31 32

uring that 12 month period, how did you get your methamphetamine?
(CODE IN ORDER OF QUANTITY OBTAINED)

1. Bought in order to sell and get enough for personal use
2. Bought for own use
3. Received it free from spouse, lover, friend or relative
4. Traded it for sex
5. Manufactured it
6. Other (Describe)_____

1st mention V233 ___
33

2nd mention V234 ___
34

3rd mention V235 ___
35

ICE SMOKING QUESTIONS

INTERVIEWER: FOR NON-ICE SMOKERS, SKIP TO QUESTION 56

43. What year did you first smoke ice? V236 ___ ___ ___ (36 37 38)

44. If you smoked just one average hit, how long would your high last?
(INTERVIEWER: CODE IN HOURS) V240 ___ (40)

45. At your peak period of ice smoking, how much do/did you estimate you, yourself, were using in a typical week?
INTERVIEWER: (GRAMS & PARTS OF GRAMS) V242 ___ ___ . ___ (42 43 44)

46. In this peak period, what is/was the street value of the ice you used?
(INTERVIEWER: CODE IN DOLLARS) V246 ___ ___ ___ ___ (46 47 48 49)

47. What is/was the total number of weeks you used approximately that amount?
(INTERVIEWER: WEEKS NEED NOT BE CONSECUTIVE) V250 ___ ___ ___ (50 51)

48. What's the most ice you have ever smoked yourself in one day?
INTERVIEWER: EMPHASIZE RESPONDENT'S USE ONLY V253 ___ . ___ ___ (53 54)
(GRAMS AND PARTS OF GRAMS)

49. How many days ago was your most recent use of ice? V256 ___ ___ ___ (56 57)
(IF USED ON DATE OF INTERVIEW, CODE 000)

50. During the last 12 month period you used ice, how many months did you use at least once? V259 ___ ___ (59 60)

51. In an average month of that 12 month period, how many days did you use? V261 ___ ___ (61 62)

52. In an average month of that 12 month period, how many grams did you, yourself use?
INTERVIEWER: (GRAMS AND PARTS OF GRAMS) V263 ___ ___ . ___ ___ (63 64 65 6)

53. During that 12 month period, typically how many days did you smoke without sleeping? V267 ___ ___ (67 68)

54. What was the longest episode in days that you used without sleeping during that 12 month period? V269 ___ ___ (69 70)

)uring that 12 month period, how did you get your ice?

(CODE IN ORDER OF QUANTITY OBTAINED)

1. Bought in order to sell and get enough for personal use
2. Bought it for your own use
3. Received it free from spouse, lover, friend or relative
4. Traded it for sex
5. Manufactured it
6. Other (Describe) _____

_____

1st mention V271 ___ 71

2nd mention V272 ___ 72

3rd mention V273 ___ 73

METHAMPHETAMINE (INCLUDING ICE) QUESTIONS

What other drugs do you typically use with methamphetamine or ice during the high?
(INTERVIEWER: LIST TOP THREE IN ORDER OF FREQUENCY)

_____ TO BE CODED LATER

_____ TO BE CODED LATER

_____ TO BE CODED LATER

1st mention. V274 ___ 74

2nd mention V275 ___ 75

3rd mention V276 ___ 76

What drugs do you typically use to come down from methamphetamine or ice?
(INTERVIEWER: LIST TOP THREE IN ORDER OF FREQUENCY)

_____ TO BE CODED LATER

TO BE CODED LATER

TO BE CODED LATER

1st mention V277

2nd mention V278

END CARD #2 7

BEGIN CARD #3

CASE NUMBER 1 2

3rd mention V304

58. Have you ever experienced a serious methamphetamine related health problem that lasted one week or more?
0 = NO 1 = YES V305
(IF NO, SKIP TO QUESTION #60)

59. IF YES: Describe your three most serious methamphetamine-related health problems that lasted one week or more.
(INTERVIEWER: LIST IN ORDER OF SEVERITY)

TO BE CODED LATER

TO BE CODED LATER

TO BE CODED LATER

1st mention V306 6

2nd mention V308 8

3rd mention V310 10

Have you ever been hospitalized for methamphetamine-related health problem(s)?

0 = NO 1 = YES V312 ___ 12

(IF NO, SKIP TO QUESTION #62)

IF YES: Describe your three most serious hospitalizations.

_____ V___ (CODE LATER) _____ (length of stay) (CODE IN DAYS) V313 ___ 13 ___ 14 ___ 15

(problem)

_____ V___ (CODE LATER) _____ (length of stay) (CODE IN DAYS) V316 ___ 16 ___ 17 ___ 18

(problem)

_____ V___ (CODE LATER) _____ (length of stay) (CODE IN DAYS) V319 ___ 19 ___ 20 ___ 21

(problem)

Have you ever experienced any of the following methamphetamine-related problems?

0 = NO 1 = YES

a: Severe weight loss?..... V322 ___ 22

b: Severe sleeplessness?..... V323 ___ 23

c: Severe memory loss?..... V324 ___ 24

d: Severe chest pains?..... V325 ___ 25

e: Seizures?..... V326 ___ 26

f: Severe depression?..... V327 ___ 27

g: Chronic anxiety?..... V328 ___ 28

h: Panic attacks?..... V329 ___ 29

i: Hallucinations?.(auditory or visual)..... V330 ___ 30

j: Severe Paranoia?..... V331

k: Committed violent acts?..... V332

l: Serious accidents?.....V333

m: Other.(IF NO, SKIP TO QUESTION #63)..... V334
(IF YES, DESCRIBE THE THREE MOST SERIOUS "OTHER" PROBLEMS, IN ORDER OF IMPORTANCE)

_____ V335 ___
TO BE CODED LATER 35

_____ V337 ___
TO BE CODED LATER 37

_____ V339 ___
TO BE CODED LATER 39

3. How would you describe your sexual preference?

1 = Heterosexual 2 = Homosexual 3 = Bisexual
4 = Other (Specify) _____ V341 ___

4. Has methamphetamine use affected your sexual behavior in any of the following ways?

0 = NO 1 = YES

1. Increased sexual activity?..... V342 ___

2. Decreased sexual activity?..... V343 ___

3. Difficulty reaching orgasm? ..... V344 ___

4. Changed type of sexual activity?..... V345 ___

5. (FOR MEN ONLY) Difficulty in achieving/maintaining erection? V346 ___
(IF RESPONDENT IS FEMALE, ENTER 9)

(FOR WOMEN ONLY) Did you ever use methamphetamine while pregnant?
(IF RESPONDENT IS MALE, ENTER 9) 0 =NO 1=YES 2=DON'T KNOW V347 ___

ave you had an HIV test? V348 ___ 48
0 = NO 1 = YES
(IF NO, SKIP TO QUESTION #70)

IF YES) Approximately how many months ago was your ast AIDS test? V349 ___ ___ ___ 49 50 51

as the result of the test: V352 ___ 52
ODES: 0=NEGATIVE 1=POSITIVE 2=DON'T KNOW
IF NEGATIVE, SKIP TO QUESTION #70)

ave you been diagnosed as having AIDS/ARC? V353 ___ 53
0 = NO 1 = YES

ver the last 12 months, how many sexual partners do ou estimate you have been with? V354 ___ ___ ___ 54 55 56

uring the past 12 months, with how many of these exual partners did you use <u>disease</u> protection? V357 ___ ___ ___ 57 58 59
CONDOM, LATEX, ETC)
INTERVIEWER: IF 000 SKIP TO QUESTION #73)

hen you're with a sexual partner with whom you use isease protection, how often do you use it? V360 ___ 60

CODES: 1=RARELY 2=LESS THAN HALF THE TIME
3=HALF THE TIME 4=MORE THAN HALF THE TIME 5=ALWAYS

as methamphetamine created serious problems in ny of the following relationships during your last 2 months of use?
0 = NO 1 = YES 9 = N/A

a. Spouse/Lover?..... V361 ___ 61

b. Family members?..... V362 ___ 62

c. Friends?..... V363 ___ 63

d. Co-workers?..... V364 ___ 64

4. Has methamphetamine created serious problems with work and/or school during your last 12 months of use?

0 = NO 1 = YES 9 = N/A

a. With work?..... V365 ___ 6(

b. With school?..... V366 ___ 6(

c. Lost a job?..... V367 ___ 6(

d. Dropped out of school?.....V368 ___ 6(

5. Has methamphetamine created any severe money problems during the last 12 months of use?

0 = NO 1 = YES 9 = N/A V369 ___ 6(

6. In the last 12 months, did you feel that you had lost control over your methamphetamine use at any time?

0 = NO 1 = YES V370 ___ 7(

7. In the last 12 months of use, at any time did you think you were addicted to methamphetamine?

0 = NO 1 = YES 2 = DON'T KNOW V371 ___ 7(

3. During the last 12 months of use, have you ever seriously tried to quit using methamphetamine?

0 = NO 1 = YES V372 ___ 72
(IF NO, SKIP TO QUESTION #81)

). (IF YES) How many times? V373 ___ ___ 73 7(

). What were your three main reasons for quitting or trying to quit methamphetamine?
(IN ORDER OF IMPORTANCE)

_____ V375 ___ ___ 75 7(
TO BE CODED LATER

_____ V377 ___ ___ 77 7(
TO BE CODED LATER

END OF CARD #3 0 3
BEGIN CARD #4 79 80

CASE NUMBER ___ ___ ___
1 2 3

V404 ___ ___
4 5

TO BE CODED LATER

LEGAL HISTORY

Have you ever engaged in any of the following illegal activities?
(EITHER AS AN ADULT OR AS A JUVENILE)
0 = NO 1 = YES

1. Drug sales?.....V406 ___ 6
2. Drug manufacture?.....V407 ___ 7
3. Burglaries?.....V408 ___ 8
4. Armed Robberies?.....V409 ___ 9
5. Assaults?.....V410 ___ 10
6. Auto theft?.....V411 ___ 11
7. Fraud/forgery?.....V412 ___ 12
8. Prostitution?.....V413 ___ 13
9. Boosting/shoplifting?.....V414 ___ 14
10. Other?_____ V415 ___ 15

(IF NO TO ALL OF THE ABOVE SKIP TO QUESTION #83)

82. Have you engaged in any of the following illegal activities because of y methamphetamine use? (EITHER AS AN ADULT OR AS A JUVENILE)

0 = NO 1 = YES

1. Drug sales?.....V416 _

2. Drug manufacture?.....V417 _

3. Burglaries?.....V418 _

4. Armed robberies?.....V419 _

5. Assaults?.....V420 _

6. Auto theft?.....V421 _

7. Fraud/forgery?.....V422 _

8. Prostitution?.....V423 _

9. Boosting/shoplifting?.....V424 _

10. Other?_____V425 _

83. Did you ever spend time in a juvenile institution? (IF NO, SKIP TO QUESTION #86)

0=NO 1=YES V426 _

84. IF YES, How many total days did you spend in a juvenile institution? V427 ___ ___ (27 28)

85. Were drug charges involved in your institutionalization?

0=NO 1=YES V430

86. As an adult, have you ever been convicted of a felony?

0 = NO 1 = YES V431

(IF NO SKIP TO QUESTION #89)

87. If YES, how many times? V432 ___ (32)

: were these felony convictions?
OVER THREE, LIST THE FELONIES RESULTING IN THE LONGEST
IODS OF INCARCERATION)

_____ V ____ TIME SERVED IN MONTHS V434 ___ ___ ___
TO BE CODED LATER 34 35 36

_____ V ____ TIME SERVED IN MONTHS V437 ___ ___ ___
TO BE CODED LATER 37 38 39

_____ V ____ TIME SERVED IN MONTHS V440 ___ ___ ___
TO BE CODED LATER 40 41 42

e you ever been convicted of a misdemeanor? V443 ___
0 = NO 1 = YES 43
(IF NO, SKIP QUESTION #92)

YES, how many times? V444 ___ ___
44 45

e any of these drug charges (including Alcohol)? V446 ___
0 = NO 1 = YES 46

e you ever spent any amount of time in jail or prison? V447 ___
0 = NO 1 = YES 47

much time (IN DAYS) have you served in jail? V448 ___ ___ ___ ___
48 49 50 51

much time (IN MONTHS) have you served in prison? V452 ___ ___ ___
52 53 54

e you ever received any kind of treatment for your
g or alcohol use? 0 = NO 1 = YES V ___

[IF NO, END OF QUANTITATIVE SECTION]
YES, List each of the treatment programs or modalities.

_____ _____ _____

_____ _____ _____

at was/were the primary drug(s) involved in your entry into treatment?

_____ _____ _____

_____ _____ _____

w many treatment episodes primarily involved methamphetamine V ___ ___
d/or Ice?

THANK YOU FOR YOUR COOPERATION

APPENDIX B
STIMULANT GUIDE

1. *Pharmaceutical Stimulants*

GENERIC NAME	BRAND NAMES
Methamphetamine	*Methedrine, Desoxyn*
Amphetamine	*Benzedrine* (Bennies, White Crosses)
Dextroamphetamine	*Dexedrine* (Dexies, Pink Hearts)
Amphetamine/ Dextroamphetamine Combo	*Biphetamine* (black beauties) *Obetrol, Delcobese*
Dextroamphetamine/ Amobarbital Combo	*Dexamyl* (Christmas Trees)
Dextroamphetamine/ Prochlorperazine Combo	*Eskatrol*
Benzphetamine	*Didrex*
Methylphenidate	*Ritalin*
Diethylpropion	*Tenuate, Tepanil*
Mazindol	*Mazanor, Sanorex*
Phendimetrazine	*Bontril, Melfiat, Plegine, Prelu-2*
Phenmetrazine	*Preludin*
Phentermine	*Adipex, Fastin, Ionamin*

2. *Over-the-counter (OTC) Stimulants*

Phenylpropanolamine (PPA)	Leading OTC appetite suppressant; Many brands--Dexatrim most commonly advertised
Caffeine	Most popular caffeine tablets are No-Doz and Vivarin. Also primary ingredient in guarana or Zoom tablets.
Ephedrine	Many brands of decongestants-- also primary drug in many Chinese herbal stimulants such as Ma Huang.

APPENDIX C

HONOLLULU SITE CHARACTERISTICS

DISTRICT #	*NAME*	*# OF RESIDENTS (*)*	*CHARACTERISTICS*
1	Hawaii Kai	25,603	upper m/c area: 31% white and 52% Chinese or Japanese ethnicities
2	Kuliouou	15,933	
3	Waialae-Kahala	11,362	
4	Kaimuki	19,930	
5	Diamond Head	21,574	upper m/c area: 38% and 58% of Chinese or Japanese ethnicities
6	Palolo	14,103	
7	Manoa	23,961	
8	McCully/Moiliili	26,471	
9	Waikiki	18,860	
10	Makiki	28,456	
11	Ala Moana/Kakaako	11,327	
12	Nuuanu/Punchbowl	16,847	
13	Downtown	11,653	
14	Liliha/Kapalama	23,331	
15	Kalhihi/Palama	40,118	lower ses area, high proportion of public housing: 60% Filipino, 25% mixed Hawaiian
16	Kalihi Valley	17,809	
17	Moanalua	12,927	
18	Alimanu/SaltLake	37,247	
19	Airport	28,514	
20	Aiea	34,522	
21	Pearl City	49,451	
22	Waipahu	51,625	dense low income and fastest growing (+55% from 1980-1990 census): 50% Filipino,
23	Ewa	39,516	
24	Waianae Coast	35,121	low-income, semi rural: 30% Filipino, 30% mixed Hawaiian and the rest Samoan or "local"
30	Kaneohe	42,086	
31	Kailua/Mokapu	55,058	
32	Waimanalo	9,091	

(*) Population figures taken from the 1990 census

Pseudoephedrine	Many brands of decongestants--Sudafed best known
Phenylephrine	Many brands of decongestants
L-Desoxyephedrine	Vicks Inhaler

3. *Common Terms for Different Types of Methamphetamine*

Prope Dope	meth made with P2P, usually sticky and brownish in color; used before Ephedrine available; common to bikers gangs
Crank	biker term for methamphetamine, usually made with P2P
Peanut Butter Crank	meth associated with outlaw biker gangs.
Crystal	common name for methamphetamine
Glass	crystalline methamphetamine of high quality
Rocket (or Jet) Fuel	very strong meth; also term for meth powder in Hawaii
Sparkle	high quality methamphetamine with a "sparkle" or shine

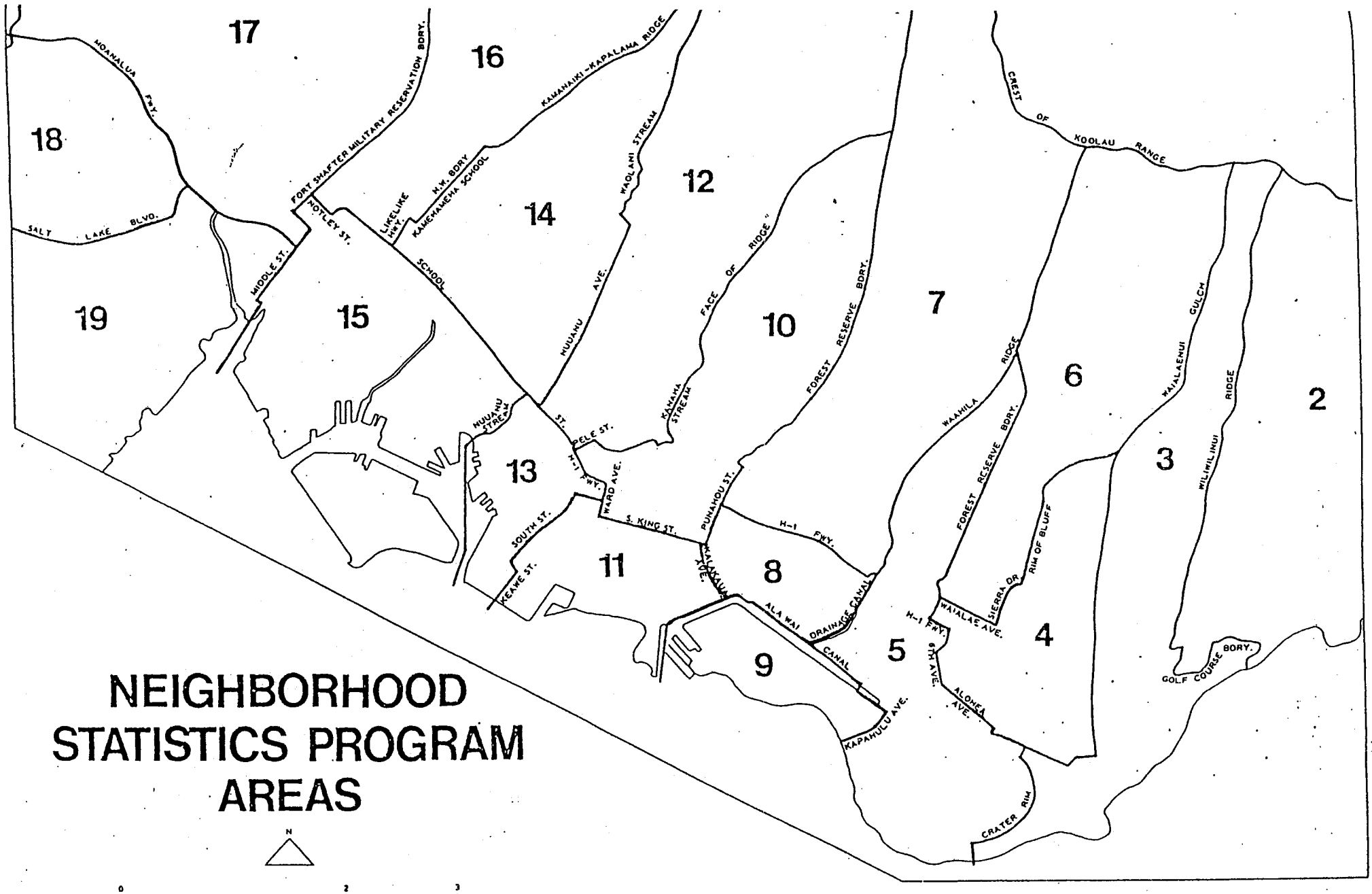
4. *Ice*

Crack Meth	term for "rock" or ice methamphetamine
Glass or L.A. Glass	thought to be the same as ice, in appearance and affect
Ice Cream	methamphetamine in the ice form
Hiropon	Korean name for methamphetamine [ice]
Batu	Filipino name for methamphetamine [ice]
Shabu	Japanese term methamphetamine [ice]

5. *Less Common Terms for Methamphetamine*

C.M.A.	Crystal Meth Amphetamine
Clear Lake	methamphetamine the Clear Lake area
Gardenia	methamphetamine with a flower taste/smell
Lemondrops	name for meth with a yellowish color
Mr. Brownstone	a brown colored meth, very strong and smelly
Quartz	methamphetamine with crystal flakes
Rock	solid hard methamphetamine chunks
Yellow Crunch	methamphetamine with a yellow color

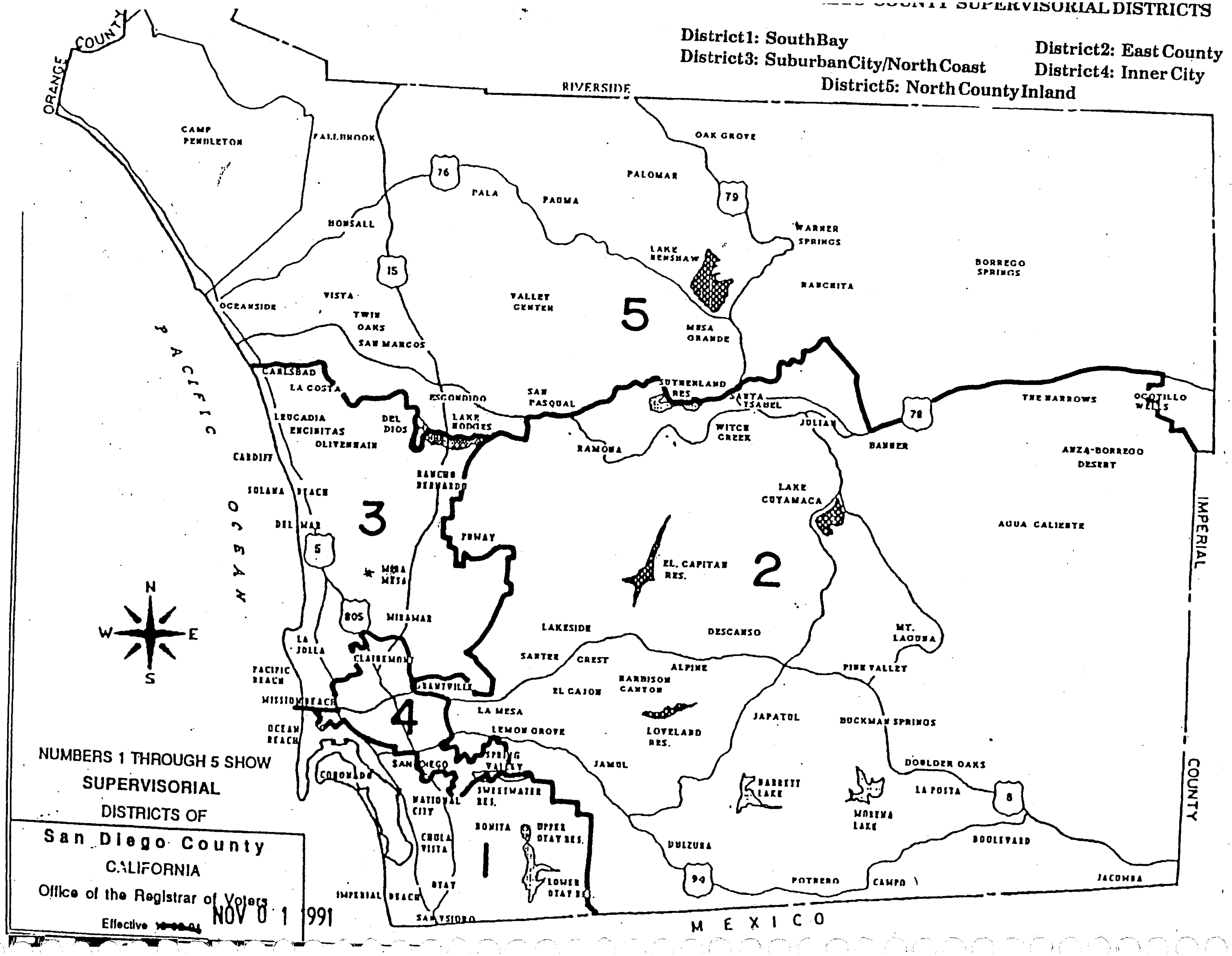
Other local terms for methamphetamine in general include: go fast, jib, pink champagne, do, chrissy, dope.



NEIGHBORHOOD STATISTICS PROGRAM AREAS

COUNTY SUPERVISORIAL DISTRICTS

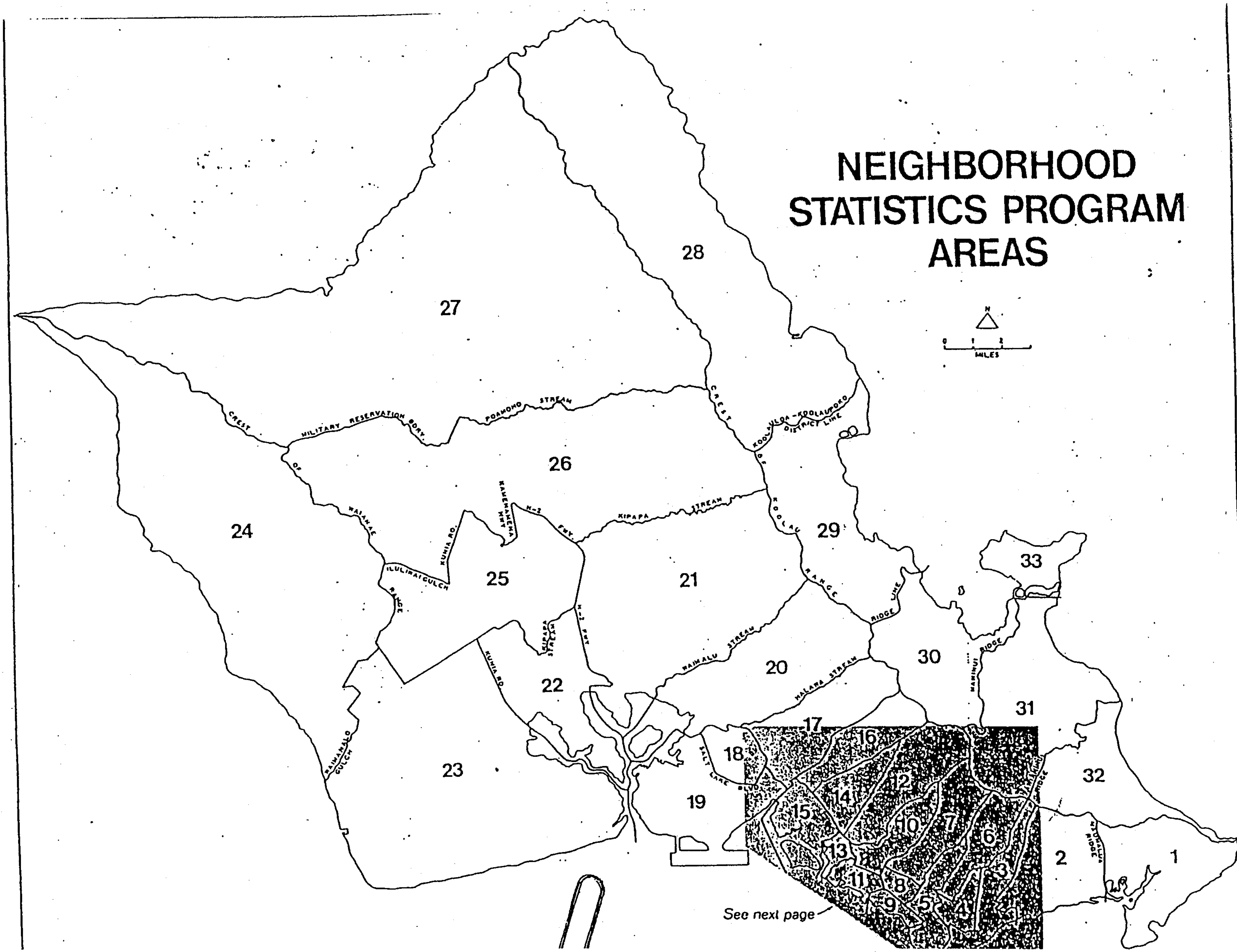
District1: SouthBay
District2: East County
District3: SuburbanCity/North Coast
District4: Inner City
District5: North County Inland



NUMBERS 1 THROUGH 5 SHOW SUPERVISORIAL DISTRICTS OF

San Diego County
CALIFORNIA
Office of the Registrar of Voters
Effective ~~10-08-91~~ NOV 0 1 1991

NEIGHBORHOOD STATISTICS PROGRAM AREAS



APPENDIX D

CONSULTANTS

LISTED BY STUDY SITE:

RESEARCH STAFF

RESEARCH CONSULTANTS

COMMUNITY CONSULTANTS

PROFESSIONAL CONSULTANTS

FACILITATING ORGANIZATIONS

APPENDIX D

RESEARCH STAFF, COMMUNITY CONSULTANTS, PROFESSIONAL CONSULTANTS, AND KEY FACILITATING ORGANIZATIONS

This research involved over 150 individuals who contributed in a variety of roles, from full time research staff to focus group participants, and from a single consultant interview to continuous active contribution. Many volunteered their time in exchange for preliminary findings presentations, especially professionals in public sector agencies. Often individuals would serve in a number of different capacities over the life of the project. Therefore in order to simplify the process of acknowledments, the major contributing roles are defined below. This is followed by an alphabetical listing of the individuals and organizations actively participating in the study.

Research Staff: Individuals acting as administrative personnel, interviewers, ethnographers, project and study site coordinators, and senior investigators.

Community Consultants: Individuals who provided ethnographic and other informational material; and/or periodic feedback and advice on sampling and data collection instruments, on emerging conceptual categories, and/or on the validity/reliability of preliminary findings.

Professional Consultants: Included agency, program and organization directors and/or senior staff from criminal justice, health, social service and substance abuse fields; community-based professionals including directors of community-based organizations; academic experts and leading research scientists in relevent fields.

Facilitating Organizations: Organizations which volunteered space, personnel and resources for this study, including programs, community agencies, and academic institutions.

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APPENDIX E

PRESENTATIONS AT PROFESSIONAL MEETINGS

Beck, J. "XTC, LSD and Speed: Dance Drugs and the Rave Scene," Paper presented at the Fifth International conference on Drug Policy Reform, Washington, DC. November, 13, 1992.

Beck, J. "Patterns and Problems among Methamphetamine Users in Honolulu, San Diego and the San Francisco Bay Area: Preliminary Findings of a Naturalistic Study." Paper presented at the Substance Abuse Grand Rounds, Veterans Administration Medical Center, San Francisco, February, 1993

Estep, R. and P. T. Macdonald, "Methamphetamine use and Sex in three U.S. Cities" paper presented at the Annual Meeting of the American Society of Criminology. New Orleans, 1992.

Joe, K. "Power and Priorities": Gender Issues and Hawaiian Ice," Paper prepared for presentation at the 51st Annual Meeting of the American Society of Criminology. New Orleans, Nov. 1992.

Morgan, P. "Context and the Role of Alcohol Among Methamphetamine Users: A comparative Analysis" paper presented at the 20th annual meeting of the Epidemiology Section (Kettil Bruun Society), International Council on Alcohol and Addiction, June, 1994

Morgan, P. "Researching Hidden Communities: A qualitative Comparative Study of Methamphetamine Use in Three Sites" paper presented at the National Institute on Drug Abuse, Community Epidemiology Work Group Meetings. San Francisco, December, 1993

Morgan, P. & K. Joe, "The Economic Enterprise: The Entrepreneurial World of Female Methamphetamine Users" presented at the Society for the Study of Social Problems meeting, Miami, August, 1993.

Morgan, P. "Crystal Methamphetamine: A Comparison of the Hawaii and California Experience." Paper presented at the Hawaii Sociological Association meetings, Honolulu, March 20, 1993.

Morgan, P., Beck, J., Mc Donnell, D., Joe, K., Estep, R., "Shooters, Snorters and Smokers: A Comparison of Methamphetamine Users in Honolulu, San Diego and the San Francisco Bay Area," Paper presented at the American Society of Criminology, 44th Annual Meeting, New Orleans, November, 1992

ADDITIONAL PRESENTATIONS:

California State Epidimiology Work Group: Annual presentations of preliminary findings 1991, 1992, 1993. (by Beck, McDonnell and Morgan)

Honolulu Community Epidemiology Work Group: Annual presentations of preliminary findings 1992, 1993, 1994. (by Morgan and Joe)

Australia National Drug and Alcohol Research Center: presentation of preliminary findings (by Morgan)

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APPENDIX E

PUBLICATIONS

Beck, J.E. "From Pills to Powders: The Problematic Evolution of Clandestine Methamphetamine in California." Forthcoming in: Amphetamine Misuse: International Perspectives on Current Trends H. Klee (Ed.) Harwood Academic Publishers: London.

Joe, K., "The Life and Times of Asian American Drug Users: Accessing and Exploring Minority Drug Use Issues Through Ethnography," Journal of Drug Issues (in press)

Joe, K., "Ice is Strong Enough for a Man, But Made for a Woman: A social and Cultural Analysis of Methamphetamine Use Among Asian Pacific Americans" submitted for review: Crime, Law and Social Change

McDonnell, D. and J. Beck, "Crank and Crystal: The Emergence and Evolution of Clandestine Methamphetamine in the Bay Area," Journal of Drug Issues (in press)

Morgan, P. "Researching Hidden Communities: A Qualitative Comparative Study of Methamphetamine Users in Three Sites," Proceedings of the December, 1993 Community Epidemiology Work Group. National Institute on Drug Abuse, Department of Health and Human Services, Washington, D.C. (in press).

Morgan, P., J. Beck, D. McDonnell, K. Joe, and R. Gutierrez. "Ice and Other Methamphetamine Use: Preliminary Findings From Three Sites." National Institute of Drug Abuse Monograph, (in press)

Gorman, M., P. Morgan, C. Clay, "'As Real as it Gets:' Methodological Concerns on Speed Use Among Gay and Bisexual Men" forthcoming in NIDA research Monograph, Qualitative Methods in Drug Abuse and HIV Research

Morgan, P. and K. Joe, "Citizens and Outlaws: Methamphetamine and the Contextual Terrain of Women's Experience in the Illicit Drug Economy" Journal of Drug Issues (in press)

Morgan, P. and K. Joe, "Uncharted Terrain: Contexts of Experience Among Women in the Social Worlds of Illicit Drugs" Submitted for publication to Women and Criminal Justice

Morgan, P. and K. Joe, "Ethnography For Women and By Women: Integrating Method and Meaning in a Study of Methamphetamine" in Women and Drugs: Research Methodologies. Proceedings of the Seventh Annual NDARC Symposium, National Drug and Alcohol Research Center, Australia (in press)