
Ansley Hamid, Ph.D.*

Abstract — Although Americans have experienced many drug epidemics, the majority of which have ended within ten years of onset, they nevertheless believed that the use of smokable cocaine, which took the popular form of crack cocaine in 1984, would grow exponentially throughout the 1990s unless it was vigorously combated. However, in 1991 it appears that crack use is in decline even in the inner-city neighborhoods where it had been most entrenched, and that the decline is due more to natural controls than to the War on Drugs. The cyclical nature of drug epidemics, as well as their progression through regular stages, was again affirmed. The cocaine-smoking epidemic of 1981–1991 (which included crack) afforded the opportunity to research it in its entirety. In this article, the advantages of recognizing the developmental cycles of drug epidemics are outlined, the most important of which concerns the future. In the terminal stage of the developmental cycle of a drug epidemic, remaining abusers play a pivotal role. If humanely treated, they may serve as deterrents to future drug use; frustrated in current drug use, however, yet insensitively treated by the wider society, they may author the next epidemic.

Keywords — cocaine smoking, crack cocaine, drug epidemics, drug policy, drug trafficking, New York City, smokable drugs

Recent declines in both crack cocaine use and distribution in New York City's low-income, minority neighborhoods have been reported by independent researchers since 1990 (Hamid 1991) and have been affirmed since then by government surveys (Hemphill 1990). There are several indicators of this trend, such as a decrease in hospital mentions, a decreasing number of children being detained at birth in hospitals as border babies (children born with cocaine-positive toxicologies), and a steep fall (from 82% in 1989 to 56% in 1990) in the percentage of arrestees testing positive for cocaine (Hemphill 1990). Taken together, they make heartening news because they indicate that even in the neighborhoods where crack cocaine hit hardest, a terrible scourge is being lifted. In the inner city, more crack abusers are becoming weary of the “mission” (the multiple tasks that crack abusers perform to earn crack or money) and far fewer distributors are active. Virtually no one in the 14- to 23-year-old age group (in which, ten years ago, some had been launched enthusiastically in their freebasing and crack-using careers) is currently interested in the drug. Apparently these young persons have not taken an interest in heroin either, although an increased supply of high-grade, low-priced heroin has allegedly appeared. The recent declines are also felicitous for researchers. The period from 1981 to 1991 can contribute much to understanding why human beings in every known culture have used drugs, and why certain drugs may sometimes become a problem for a small proportion of them because it spans the entire developmental cycle of a drug epidemic — the cocaine-smoking epidemic. Although opportunities to research the early stages of the cycle were not seized by government funding agencies, there was some painstaking

†Funding was provided by the Harry Frank Guggenheim Foundation, the Research Foundation of the City University of New York, and the National Institute on Drug Abuse. Institutional support was given by John Jay College of Criminal Justice, Narcotic and Drug Research Inc., and the Research Institute for the Study of Man.

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<tr>
<td><strong>Major Locale</strong></td>
<td>Afterhours Clubs</td>
<td>Freebase Parlors</td>
<td>Crackhouse/Apartments of Users</td>
<td>Curbside Distribution</td>
<td>Freakhouses/Curbside Distribution</td>
<td>Decline</td>
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<td><strong>Stage</strong></td>
<td>Onset</td>
<td>Incubation</td>
<td>Widespread Diffusion</td>
<td>Peak</td>
<td>Distribution</td>
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<tr>
<td><strong>Approximate Wholesale Price of Pure Cocaine ($US per kg)</strong></td>
<td>$100,000 per kg</td>
<td>$50,000 per kg</td>
<td>$36,000 per kg</td>
<td>$15,000-$20,000 per kg</td>
<td>$30,000-$36,000 per kg</td>
<td>$25,000-$30,000 per kg</td>
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<td><strong>Characteristics of Use/Sale</strong></td>
<td>Few cocaine powder distributors, intranasal use of cocaine powder, adulterated at retail. Sold in half grams ($50) and grams ($100). Bulk supply and import by US organized crime groups, not Colombians. Very controlled freebase smoking by few cocaine powder distributors and heroin injectors. Clientele resistant to trying freebase.</td>
<td>Cocaine powder/marijuana distributors and other newcomers experiment with preparation of freebase from cocaine powder for purchaser; share in use of freebase. Experiment with various ways to sell freebase. Became compulsive cocaine smokers or freebasers. Bulk supply and import handled by Colombian freelancers along routes through Caribbean Islands and Central America. Sales of half-gram ($50), gram ($100), and tin foil packages ($20). Baking soda sometimes added at buyers' request for self-preparation. The term &quot;crack&quot; applied to prepared, prepackaged freebase. Limited sales of crack in vials begin.</td>
<td>Younger, nonusing distributors emerge to sell crack and to replace former user-distributors who became compulsive users. Smoking crack largely replaces snorting and self-prepared freebase. Rapid expansion of crack sold in vials dominates market and surpasses powder sales. Bulk supplies and imports handled by Colombian cartels or Dominicans/Cubans. Higher-level distributors attempt businesslike organizations, such as posses/gangs, but these did not last long in New York City.</td>
<td>Frequent (many times per day) crack use, instant buying and use. Missions or binges commonplace. Many crack users engage in sales to support own use. Police bust many street sellers, and incarcerate many. Peak period of crack use and distribution. Variety of distributors, teenage sellers. Higher-level suppliers provide to free-lance sellers. GANGS/Posses are rare. Emergence of Dominicans as bulk suppliers.</td>
<td>Population of neighborhood crack abusers declines as many go to jail, join treatment programs, migrate, become abstinent or die. Powerful emergent norms discourage experimentation and use among youths under 23. Population of crack distributors declines. Remaining curbside distributors make moderate incomes. Freakhouses (i.e., &quot;freakhouses&quot;) of an elderly male crack user and several female abusers) emerge as premier locales in neighborhood for crack use. Many working-class or middle-income males visit freakhouses for sex, not crack.</td>
<td>Cocaine powder sales from Dominican bodegas appear to outstrip crack sales in many neighborhoods in the five boroughs of New York City. Youths from high-risk backgrounds avoid crack, but use alcohol, marijuana, and intranasal cocaine powder (called &quot;Nitro&quot;). Other drug use? Increase in heroin consumption hypothesized among current and ex-heroin users. Sniffers/smokers/injectors only.</td>
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work done by a number of scholars (Maher & Curtis In press; Dunlap 1992; Hamid 1990b; Johnson et al. 1990; Bourgois 1989; Williams 1989), while the later stages were both researched and reported extensively by the media. Materials for an overall assessment are therefore available.

OVERVIEW

Ethnographic experience of the complete developmental cycle of the cocaine-smoking epidemic has enabled researchers to differentiate and describe six stages through which it progressed. Successive contexts for cocaine use, and especially the five for cocaine smoking exclusively, permitted the diffusion of the practice from one social segment to another, erasing social distinctions, creating new ones, and allowing cocaine use to acquire new meanings and effects (Hamid 1992a). Various social policies, different law enforcement strategies, rates of incarceration, and more importantly, internal contradictions in economic, cultural, and social forces operating among users and dealers, pushed the cycle from one stage to another. It was as if six distinct drugs had been introduced, each following the other in rapid succession. If it is true that a lengthy incubation period — unfolding among a few initiates in secluded, experimental settings — is required for the safest and most benign introduction of a drug to a wider human population, some of the malign effects of cocaine smoking may be due to the brevity and rapid succession of the six stages (Hamid 1989). Table 1 summarizes the developmental cycle of the epidemic; the stages are described below.

AFTERHOURS CLUBS (1979-1981)

The groundwork for the cocaine-smoking epidemic in low-income, minority neighborhoods was laid when cocaine (hydrochloride) powder — for intranasal use or snorting — became popular in restricted circles around 1979. Many persons who initiated cocaine use then remained active and central throughout the epidemic, metamorphosing as they traversed the six stages and initiating successive categories of users.

The chief locus for the use and distribution of the drug in 1979 was the afterhours club. Fashionable persons in minority communities — with large disposable incomes, both legal and illegal — patronized these clubs and cocaine snorting enhanced their feelings of the demimonde, of affluence, and of romance. At $100 or more per gram (usually cut or adulterated), cocaine was a luxury good, and its use was linked with the consumption of other luxury items, such as quality champagnes or wines.

The increased popularity of intranasal cocaine greatly enriched and lionized the few cocaine powder distributors then resident in minority neighborhoods. They were the first cocaine smokers in the current epidemic. Although cocaine smoking has been known for over 100 years, these few were the only ones who smoked it in 1981. The outstanding feature of their use was its controlled, discreet nature. Their expenditure of time and money on smokable cocaine for personal use in no way threatened their role as cocaine distributors, nor did the practice interfere with the smokers’ other interests. For example, one individual who contributed enormously to ethnographic research was an accomplished artist who exhibited an impressive corpus of paintings and sculptures at his apartment where he sold cocaine (Hamid 1990b). When they offered freebase to their snorting clientele, it was refused. The rebuff further marginalized and contained cocaine smoking.

A step on the road from the intranasal use of cocaine to smoking it (and from its use by the affluent to popular use, or from luxury good to commodity) was its rediscovery by ex-heroine injectors. The cutting edge or avant-garde of drug subcultures since the Harrison Act in 1914, many heroin injectors had surrendered to methadone at the end of the heroin-injecting epidemic of 1964-1972 (Clayton & Voss 1981; Boyle & Brunswick 1980). After a few years, however, they had grown dissatisfied with the round of methadone, cheap liquor, intranasal cocaine, and marijuana, which constituted their version of methadone maintenance, and in the late 1970s initiated cocaine injecting. But by 1981, cocaine injecting had become frustrating, and they found relief in cocaine smoking instead.

However, the crucial turning point occurred when the drug was introduced to Rastafarian marijuana distributors around 1981. Marijuana use and distribution had been the major drug involvement in these communities since the 1960s (barring alcohol use and a small heroin subculture), and Rastafarians had dominated them. By 1981, they had established an extensive international marijuana trading network, which encompassed cultivation on the Caribbean Islands, import into the United States, and small stores (often fully stocked candy stores, bodegas, record stores, clothing boutiques, vegetable shops, health food stores) in New York City’s minority neighborhoods, from which they sold marijuana to the terminal consumer. In that year, however, they suffered serious setbacks due to shortages of marijuana occasioned by crop eradication efforts, interdiction, the diversion of Colombian marijuana cultivators to coca cultivation, and vigorous street-level law enforcement in American and Caribbean cities (Hamid 1992d, 1989).

Seeking a new medium of exchange for the trading network and to provide revenues for a program of local-level reinvestments, Rastafarian marijuana distributors overrode their strong religious misgivings against cocaine, which many free-lance (i.e., pre-cartel) Colombian entrepreneurs had made plentifully and cheaply available on the Caribbean Islands, and experimented both in its use
and distribution. Their volume of business (as well as their avoidance of such worldly places of entertainment) outstripped and bypassed the capability of afterhours clubs and their suppliers. Because Rastafarians attached spiritual significance to "smoke" or the method by which they consumed marijuana, they preferred freebasing to intranasal use and helped to promote this method of administration.

FREEBASE PARLORS (1982-1984)

The appetites of Rastafarians for freebase — made enormous because they had at hand previously accumulated marijuana revenues to feed them — soon overwhelmed the capability of the few cocaine powder distributors who were active at the time. Some who had been freebasing in a controlled manner for several years were infected by the cocaine fever of their Rastafarian clientele: their consumption shot up sharply, they craved the drug for the first time, their personal use consumed both profits and product, and they destroyed their viability as distributors. Next, Rastafarians succeeded them in distribution and were similarly undone. The locales where the unraveling of long-established, sophisticated, Rastafarian drug distribution careers took place were called freebase parlors.

In freebase parlors, the rudimentary chemistry of preparing freebase and the methods of smoking it were all-consuming rituals. Freebasers experimented to arrive at the ideal mix of baking soda, cocaine and water, and to find the best heating source to cook up the mixture into freebase. Next, they were concerned with the condition of their water pipes (stem, mouthpiece, bowl, grommets, screens) and the type of flame or heat to be used to melt the freebase. Techniques of inhaling various measured quantities of the resulting vapor or smoke (directing it through either mouth or nose into either the lungs or stomach) were tested.

An extraordinary quantity of paraphernalia was required: test tubes or cooking bottles, torches of various kinds, other heating sources (such as soldering irons, a cooking range, or cotton swabs impregnated with Bacardi 151 rum), pharmaceutical dishes and instruments (e.g., scalpels for cutting and scraping, forcsps for handling freebase), lengths of wire (for scraping stems), accurate scales, and cleaning materials (rubbing alcohol, cloths, cotton-wool balls, cotton swabs, pots for boiling and cleaning the glass water pipes and their parts). A table or desk was needed for the numerous items, as well as a nearby kitchen.

As the least amount of freebase one could purchase was half a gram for $50, freebasing remained restricted to the affluent. Their fortunes began to dwindle as they spent whole weeks in freebase parlors, neglecting other business. As their clientele grew poorer, the Rastafarian or other proprietors of freebase parlors felt obliged to share freebase or were compelled by their personal craving to continue preparing fresh batches of it for their live-in company, although only they were paying.

In the closing days of freebase parlors, around 1984, their proprietors boosted revenues by admitting a clientele that had been barred previously from access to cocaine in any form, save the heavily adulterated item for intranasal use that was then being sold on the street. These were persons with small incomes and high-consumption periodicities, such as working people, petty hustlers or daily paid workers, and women maintained on public transfer payments. They were encouraged by distributors to smoke cocaine in an effort to generate sales that might hold back the final day.

CRACKHOUSES/APARTMENTS OF USERS (1984-1987)

As distributors were evicted from their freebase parlors because of nonpayment of rent and fled outstanding debts to vengeful cocaine suppliers, a flood of new distributors rushed forward to serve the rapidly expanding clientele. Typically, they were younger, nonusing males, acting independently or cooperating in loosely knit distributing groups; but variety was their hallmark, as they included schoolchildren and all sorts of part-timers (Bourgois 1989; Williams 1989). Drug distribution thus became a major employer of minority males and accounted for much of the precipitous increase in criminality reported in the mid-1980s (Pagan & Chin 1990). As the supply of cocaine had quadrupled after the rise of cartels in Colombia in 1983, cocaine prices had been falling steadily and the myriad distributors were able to sell vials for as little as $10. Preferring to separate themselves from their customers, they offered prepared, prepackaged freebase or crack.

In many neighborhoods in New York City, crack was sold briefly from crackhouses (locations set up specifically for the sale and use of crack). Elsewhere in the United States, crackhouses appear to have been the premier locales for the distribution and use of crack, and were the foundation of empires that tightly or vertically organized crack distribution businesses or posses created — Colombians, Cubans, Jamaicans in Florida and in the East, the Bloods and Crips in the West, and the Chambers Brothers and Young Boys Incorporated in the Midwest (Hemphill 1990; Taylor 1990). In New York City, crackhouses mushroomed and disappeared quite rapidly. Users were deterred by the brusque manner of the nonusing proprietors and by the strictly business arrangements on the premises. They disliked having to rent pipes and paraphernalia or being hurried to buy more crack or give up their tables to fresh customers (Hamid 1990a).
The apartments of users were more long-lasting venues, although they too were frequently wracked by crack-related quarreling. Distributors sometimes commandeered them as the tenant/user progressed further into penury. The tenant then allowed the distributor to sell exclusively to his or her local group of co-users in exchange for rent, utilities, and some free crack. As more users lost their apartments, both use and distribution moved curbside almost entirely.

**CURBSIDE USE AND DISTRIBUTION (1987-1990)**

By the summer of 1987, the prices of cocaine had fallen to the lowest level they would reach (about $450-$500 an ounce of cocaine powder or precooked as crack), and the “nickel vial” containing up to one-quarter gram of crack sold for $5, and had replaced “dimes” and “tweens” ($10 and $20 vials, respectively) as the most common unit of sale. In many neighborhoods, bargains were offered: “two for nine” [two $5 vials for $9]. In others, nickels were broken down on request into bits selling for as little as 50 cents. Thus crack was packaged and priced to meet the widest variety of demand and to make instant consumption easy. In this period, crack distribution and use were diffused from cities to remote areas of rural America. Newly initiated persons now had no idea how smokable cocaine was prepared in the first place; for them, it was something one bought in vials and consumed on the spot.

The distribution of crack citywide now shifted outdoors to curbside. To accommodate curbside use, cocaine smokers discarded the paraphernalia they had required as freebasers, and traveled light as crackheads, with only a (water pipe) stem and an inexpensive disposable lighter.

Table II shows three different forms that curbside use and distribution took. While the form of all arrangements for curbside distribution and use was geared to the most widespread diffusion of both, a balance was sought between complete anarchy and complete regulation. The three situations indicated in Table II describe some of the balances that were actually achieved.

**Free-lance Nickels Market**

In many neighborhoods very little regulation occurred, and a reputation for crack-related violence, crime, and incivility was won instead. In free-lance nickels markets, two dramatis personae in particular created the high-risk, high-energy, fast-burnout atmosphere (Hamid 1992b). One was the street-level, daily compulsive user/free-lance distributor. Typically a young minority male in his mid-twenties, he had surrendered to two fantasies: to become a millionaire through selling crack and to “smoke lovely” (smoke cocaine unrestrainedly). The war between the contrary pulls of these two fantasies accounted for his behavior on the street. This type of distributor was on the one hand very much a businessman who was always in an urgent rush to sell crack. On the other hand, the urgency also arose from his being a user who needed to sell the product before he consumed it himself. Ending each day as penniless as yesterday, he had to resort to petty criminality or rely on friends and family to have $50 the following morning to make the minimum bulk purchase (half a gram) from higher-level distributors. On the street, he competed aggressively for customers and ensnared some by offering free samples (of which he would contrive to consume the greater share).

Complementing the style of the aggressive free-lance distributor was the daily compulsive user. Negotiating crack use among such distributors, he or she was, in Williams Burroughs’ phrase, like the ball in a pinball machine. Although some of them — especially at the beginning of their crack-using careers, when they had money and jobs — could afford to buy bulk quantities from higher-level distributors and thus minimize risk and ensure quality, they preferred nevertheless to buy nickels from the street-level free-lancer. They preferred to use the drug in the exposed curbside setting, perhaps desiring a sense of danger along with crack or perhaps the readily available crack-using sexual partners.

Nearly every night, in neighborhoods where free-lance nickels markets were established, there were fights, gunshots, woundings, robberies, unchecked prostitution, and visits by police, firemen, and ambulances. “Zoomers” sold bogus crack. Arrests, hospitalizations, and interventions by the various state agencies of social control (e.g., Bureau of Child Welfare) were frequent. The highest proportion of crack abusers suffering adverse psychosocial outcomes from use — loss of jobs, family, shelter, other entitlements, respect and status — was to be found in free-lance nickels markets.

**A Variant: Crack Sellers Co-op**

Where circumstances permitted, abstinent street-level free-lance distributors made cases of regulation, where both use and distribution were more restrained than in the free-lance market described above. They were especially successful where the physical terrain encouraged monopoly. One Brooklyn housing project was entirely fenced around four city blocks, with one gate per block to admit residents. Free-lancers sold crack on lawns in the middle of the compound, and could escape from there into the residential buildings before police could run up to apprehend them. A group of ten young men (mostly sons of residents, ranging in age from 18 to 29) monopolized sales in the complex. As they enjoyed the confidence of resident users, who were mostly working people, they raised the price of vials to $10, but offered jumbo vials containing more crack.
### TABLE II
**CURBSIDE CRACK MARKET DIFFERENTIATION (1987-1990)**

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<tr>
<th>Free-lance Nickels Market</th>
<th>A Variant: Curbside Distributors Co-op</th>
<th>Business Nickels Market</th>
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<tr>
<td><strong>Standard vial with crack for $5, but $3, $2 or less also sold.</strong></td>
<td>Composed of persons who routinely sell crack in the same area, but each is a free-lancer with his own supplier and responsible for own profits and losses. Several sellers agree to respect one another’s spot (about 10 yards square) on the block. They may refer customers to one another. They cooperate by providing protection (e.g., watch backs, provide change). They may travel together for bulk purchase or may pool/lend money. They sometimes create dimes ($10) and twenties ($20) markets.</td>
<td>A few owners dominate crack distribution in a neighborhood. Owners have trademarks (color of vial-plunger) and institute standard prices and work conditions in the neighborhood. No zoomers or free-lancers allowed.</td>
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<td><strong>Street-level distributor makes independent purchase of an eight-ball [1/8th of an ounce for $50], packages it for retail into 20-odd vials to earn about $120 in sales if all are sold.</strong></td>
<td>They consume it themselves.</td>
<td>Daily compulsive use associated with heroin injecting and sniffing, and alcohol abuse, rather than crack exclusively.</td>
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<td><strong>Many free-lance sellers, no/few controls regulate conduct.</strong></td>
<td>Bazaar like atmosphere, more numerous sales, stiff competition for customers’ repeat sales.</td>
<td>Owners impose rule of no crack use while selling, enforced by salaried lieutenants or runners who watch street-level distributor almost constantly.</td>
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<td><strong>Most street sellers are daily compulsive users-distributors who have a hard time selling their product before they consume it themselves.</strong></td>
<td>Greater incidence of crack abusers: crackheads, nickelonians, Klingons, crack whores, bingers.</td>
<td>For many compulsive crack users, working as a street seller for an owner is the only way to earn crack (owners prefer to offer crack rather than money as wages).</td>
</tr>
<tr>
<td><strong>Bazaarlike atmosphere, more numerous sales, stiff competition for customers’ repeat sales.</strong></td>
<td>Greater risk of buy/bust and arrest, unpredictable violence.</td>
<td>Such markets may often cater to working persons who want safety while purchasing or who engage in weekend crack binges.</td>
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<td><strong>Zoomers sell bogus crack to unwary and escape.</strong></td>
<td>Distribution slots available to teens, school-age children, part-timers and to users/sellers of other drugs.</td>
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<td><strong>Higher-level distributors provide wholesale amounts on quiet streets nearby in cash-only transactions (i.e., no consignments or credit).</strong></td>
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Business Nickels Market

In several neighborhoods, the other extreme of regulation was achieved. A few "owners" dominated all distribution in the neighborhood, and confined it to well-demarcated areas. Each owner marketed the product under a trademark (usually the color of the plunger of a vial, such as White Tops or Black Tops). They employed "runners" to discourage fresh competition, and to oversee the conduct of customers and street sellers. The latter were recruited from a pool of neighborhood crack abusers. As crack use during work shifts was forbidden, however, many sellers used alcohol or heroin instead, and sold crack in a relaxed daze. The contrast between these street-level distributors and those of the free-lance nickels market was therefore profound. Female street sellers were frequently prostitutes as well, who worked nearby "strolls." They distinguished themselves from crack abusers who provided sexual services for crack. Many customers in business nickels markets were weekend bingers who used drugs and bought sex from Friday night through Sunday, but returned to work, family, and suburban homes on Monday morning.

Business nickels markets have been attended by a more systematic kind of violence than was experienced in free-lance nickels markets. Usurpers, would-be freelancers, or zoomers were routinely gunned down, while severe pain was inflicted on street sellers or customers who broke rules laid down by owners. Owners in one neighborhood ordered the slaying of an antidrug crusader, and when gunmen sprayed her home with bullets, they killed not only the woman, but her infant daughter. In 1989, another owner commissioned the murder of a rookie policeman in Queens.

FREAKHOUSES (1990-PRESENT)

Since the spring of 1990, the street prices of crack in New York City have been rising steadily. After rising to about $36,000 per kilogram in December 1991, the price has stabilized at $25,000-$30,000 at the time of writing (May 1992). Price fluctuations and other indicators suggest that demand has declined, and that the population of users is decreasing. When demand for a commodity declines, prices usually fall. However, commodities like crack have inelastic demands, or are largely unaffected by price fluctuations, for at least two reasons. First, demand is shaped in flagrant disregard of price and availability by the same agencies that make crack "addictive." Many consumers must have it at any cost or cease being consumers at all (through successful drug rehabilitation or in spontaneous remission). And second, cocaine prices are ultimately determined by a South American oligopoly (Sabogal, Eddy & Walden 1990) rather than by competition among numerous producers or by other free-market factors affecting supply-demand and pricing.

Thus prices have increased, and crack per dollar has decreased because crack distributors must now extract accustomed levels of profit from a diminishing number of people. South American producers may have decided to seek other markets because the North American ones have peaked, and consequently they are supplying these markets with less product.

Recent large seizures in the United States of tons of cocaine thus acquire a new significance. Cocaine is being stockpiled in these quantities, probably for transshipment to Western or Eastern European countries, where very recent crack use (sometimes the first of any drug use except alcohol) is being reported (Drucker 1990).

Giving their own opinions, crack distributors and abusers have reported, with some initial shock or surprise, that their numbers did appear to be dwindling and that they were seeing "the same old faces." "Three in a zillion are the new faces I see," declared one 23-year-old abstinent distributor to a journalist in Central Harlem (Hemphill 1990). None reported initiating crack use after 1987, except some elderly males (see below). They all agreed that persons under 23 years of age appeared to be entirely uninterested in the drug, and female users complained that young people sometimes assaulted them out of spite.

Several reasons may be advanced to explain the stagnation in demand for crack in low-income minority neighborhoods in New York City. One is that natural limits have been reached: all commodities must come up against the consumer who will not buy them. Beef cannot be sold to a vegetarian, nor can a fur coat be sold to an animal-rights activist. All the persons who were at high risk of onset to crack have become users already, and its chronic daily use appears to have affected primarily those who are today older than 23. Certainly, complex processes determine the ebb and flow of drug markets (Hamid 1992c; Becker 1967). For example, inasmuch as crack operated as an instrument of capital depletion in low-income neighborhoods and rapidly removed capital from the local level, a limit may have been reached that does not tolerate the movement upward and out of any more dollars or resources (Hamid 1991).

Another reason is that crack users and distributors have been dispersed from neighborhoods. Thousands have been removed to prisons and jails (National Institute of Justice 1990), and thousands more have dropped from sight into the city's shelter and relief systems for the homeless or into the independent ones of vagrants. Others have migrated to escape problems and/or crack. Many are hospitalized and some have died.

Stressed by crack-related misery for at least three years, many abusers have sought treatment or have been prodded into it by court mandates. Accordingly, many have left the neighborhood to live in residential drug treatment
programs. Still others are sheltered, for a fee, by maiden-aunt ("auntie") entrepreneurs. Usually a single elderly woman with an apartment and strong church or community ties, she offers beds, meals, a curfew or other discipline, a drug-free environment, and encouragement to persons awaiting treatment slots. In exchange, she receives food stamps and modest amounts of cash. The remainder attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings regularly, or quit on their own by taking jobs and creating new interests.

Failure to attract new users and loss of the old ones has depressed the condition of crack abusers remaining in the neighborhoods. Fewer users means that fewer energies and ultimately less money are available, precisely at a time when crack is more expensive; and users appear more isolated and marginalized. As more of them are accepted into treatment, they feel demoralized at being left out.

The view that the population of users and distributors is not growing or may be in decline is supported further by the very recent appearance of new social organizational forms in the population of users and distributors, notably freakhouses. Crack users are beginning to belong to households in which the leaseholder is an elderly crack-using male, or one of the few younger males or females still able to afford an apartment. These households, which were first observed during June 1990 in several low-income minority neighborhoods in New York City, are organized as follows: the elderly man receives sexual services and gifts of crack from a core group of five or six crack-abusing women. In exchange, they gain a sanctuary in highly transient lifestyles, where they can wash, prepare meals or feel at home. They promptly attract several other crack-abusing women, and the combined "harem" lures male users and working men of all ages. The latter come to "freak" (use any and all of the women sexually — a favorite pastime is "flipping," with the male going from one to as many women that are present in continuous succession), and some use crack (but many do not). The visitors pay the old man or one of his appointees cash or crack for any activity: going out to buy crack, beer or cigarettes; use of private space (by the half hour); or access to the women. Crack distribution in the freakhouse is strictly forbidden and users send out for purchase from a curbside distributor (Hamid 1992a).

The freakhouse is a culmination of social processes at work both in the crack-using population and in the low-income neighborhood at large. While the real income and other benefits of elderly men or senior citizens have improved appreciably in the past two decades (Weir et al. 1988), young women have seen their income decline steeply over the same period of time, while young men have never received outright cash handouts from the state. The freakhouse household acknowledges the greater resources and higher status an elderly man may have vis-à-vis several segments of descending generations, and responds to the women's homelessness and high mobility, which have resulted from at least three years of crack abuse.

Especially when contrasted with the preceding period of curbside use and distribution, which provided formats for the rapid, widespread diffusion of crack use, freakhouses speak of its contraction (Hamid 1991). However, declining crack use in freakhouses portends even greater trouble than has already been attributed to it. The risk of heterosexual transmission of AIDS is compounded when individuals have contracted other sexually transmitted diseases and have multiple sexual partners. In its decline, therefore, the cocaine-smoking epidemic intersects with disease and death (Des Jarlais et al. In press; Minkoff et al. In press; Friedman et al. 1990; Fullilove & Fullilove 1989; Rolf et al. 1988).

POST-CRACK ERA? (1990s)

Youths are steered away from crack by emergent institutions that discourage experimentation or continued use. For example, now in their early twenties, some have used and distributed crack in the past but have discontinued use and have formed support groups that rally one another against recidivism. Youths under 16 have made a new pastime of ridiculing or beating up crackheads who they say disgrace neighborhoods or are nuisances or thieves (Kolata 1991). Five years ago, youngsters their age had initiated crack use after first becoming distributors, as youngsters had previously been drawn into heroin use. Nowadays, as opportunities in crack distribution are more rare or only part time, there has been no room for them.

At the same time, youths have not discontinued illicit drug use. It appears that they have opted instead for milder drug-using patterns. In Flatbush, Brooklyn, several young men (18 to 20 years of age) reported drinking beer, smoking what marijuana is available, enjoying sex, and snorting "nitro" (cocaine powder). They explained that while smoking cocaine had ruined many lives, moderate snorting of nitro was pleasurable. Calling it nitro even concealed its identity with cocaine. They purchased nitro wrapped in Pyramid papers from neighborhood bodegas that had recently come under the new management of Dominican distributors.

If one considers that drug abuse is encouraged by worsening societal and personal circumstances, then the prognosis for these youths is not bright. Few have completed school or have jobs. Many were raised in dysfunctional homes in extreme poverty and amid endemic drug abuse (Dunlap 1992). As yet, they have continued to show no interest in heroin.
The first lesson to be learned concerns nomenclature. The United States — as well as South America (where the epidemic may have originated), Latin America, and the Caribbean Islands (which suffered onset earlier than the United States) — was afflicted by a cocaine-smoking epidemic, not a crack epidemic. The periods of freebase smoking, which preceded crack, ought not to be disregarded because they shaped further developments.

Drug Epidemics Come to an End

The second lesson is that, indeed, drug epidemics do have developmental cycles, and contrary to popular belief they will not continue rampantly unless checked by exogenous factors, such as law enforcement. They have "a beginning, a middle and end," as Aristotle recommended. The developmental cycle is characterized by periods of onset, incubation, widespread diffusion, peak, and decline. The final stage is stabilization at reduced levels of use (Becker 1967). For example, in the heroin injecting epidemic in New York City from 1964 to 1972, a brief period of onset/incubation was followed by rapid diffusion among minority (African-American and Hispanic) males in their early twenties. From 3% of that age cohort in 1963, the number of heroin injectors climbed to 20% in 1970. However, by 1973 only 13% remained heroin injectors (Boyle & Brunswick 1980; Clayton & Voss 1981). Reduced still further in number and percentage, and now in their late forties and fifties, they endure as the only heroin injectors in New York City today; succeeding generations have shunned the drug altogether. Similarly, the crack abusers of the year 2000 will be the lingering survivors of today's epidemic.

How Do Drug Epidemics Compare With One Another?

A fruitful research approach would be to set up comparisons of the different stages for several drug epidemics, to identify and explore processes (socioeconomic and political, as well as cultural and psychological) that occur in each and in the shift from one to another. For example, a protracted incubation period in which a very few initiates experiment with the drug, weeding out bad effects from the good, appears to be necessary for a drug's most benign introduction to a population. Onset of marijuana, for example, occurred in the early 1960s, but the drug became widely popular only at the end of the decade. It may be critical to an understanding of the effects of smoking cocaine to recognize that in effect it was as if it had traversed rapidly through five incubation periods in ten years — afterhours clubs, freebase parlors, crackhouses, curbside distribution, and freakhouses — in each of which significant features of set and setting were altered.

Alcohol, tea, chocolate, coffee, and tobacco have had cycles of use among European peoples for several hundred years. All are non-European in origin except alcohol, which was introduced from the Mediterranean. These drugs are today fully incorporated into the cultures of European peoples, but their foreign origin is still resisted through recurrent periods of abstinence. Another set of substances, although native to the Old World, such as fly agaric mushrooms or the great psychoactives and poisons of Medieval Europe — mandrake root, belladonna, henbane — have fallen into disuse and ill-repute with the passing of time, and are preserved today only in pharmaceutical preparations.

It appears that the more recently introduced psychoactive drugs, such as heroin, opium, cocaine, marijuana, and peyote (among others), will suffer the same fate as the latter. Although each has had several cycles over the past 200 years, they were of limited duration, and remain strictly localized, in that they in no way approached the popularity that members of the first group enjoyed.

Opponents of the idea of legalization who fear that unrestricted access to drugs would result in disastrous drug epidemics should take heart, therefore, in remembering how selective Western societies have been in the matter of drugs, and that the present age is one in which consciousness of health concerns rather than of altered states of consciousness is a major preoccupation. Accordingly, even the consumption of alcohol, tea, coffee, chocolate, and tobacco is viewed today as deviant or foolishly sybaritic.

Do Drug Epidemics Resemble Disease Epidemics or Consumer Fads?

It is important to decide how to picture the developmental cycle of a drug epidemic. For example, does it resemble the course of a disease epidemic? If it does, a suitable terminology would include "contagion," "at risk" or "disease carrier." Suitable policy measures would include "antidote," "quarantine" or "surgical removal" (i.e., pharmacological and law enforcement strategies).

Present research studies indicate that drug epidemics more resemble "spending fads" or consumer fashions. If they do, another set of concepts is needed. Why do people spend on one thing and forego other commodities, savings or investment? What transfers of capital occur when con-
sumers spend on one commodity or on a set of them? Crack appears to be an instrument of capital depletion, unlike use or distribution of other drugs (notably marijuana in its heyday from 1971 to 1981), and it has been likened to a vacuum cleaner that has removed capital (and political power) rapidly upward and out of local communities, where it was generated, for reinvestment far away (Hamid 1992d, 1990b). One is reminded again of the addiction Medieval European Catholic nobility had to that earlier group of poisons — sugar, tea, coffee, and chocolate. Added to their passion for courtly pomp and circumstance (e.g., foreign clothes, jewelry) and for building and equipping cathedrals and religious institutions extravagantly (with marbles and woods, and using craftsmen, artisans, and clergy), these (sometimes illegal) tastes proved as ravenous as crack has been for more plebeian contemporary populations. Because of this, capital passed from the nobility to those social classes whose energies fueled the Great Transformation from traditional to modern society. For whom, then, or toward what America has the crack vacuum cleaner toileted? What new world order is nurtured by the estimated $50 billion it has been extracting and shifting annually since 1981?

Users and Distributors Metamorphose Over the Course of the Epidemic

Another lesson is that the characteristics and identities of personnel change over the course of the epidemic. For example, when cycles are first generated, it appears that users initiate distribution among fairly exclusive groups of fellow users. Later, these same distributors gear up to meet increasing demand, but their personal use also increases and eventually destroys their viability in distribution. They are then succeeded by a variety of nonusing distributors. Thus, crack distributors have been correctly described as instantly and fabulously wealthy/instantly impoverished, poor and destitute/earning a middling income, organized in gangs or in tightly hierarchical businesses/individualistic free-lancers, and indoors (freebase parlors, crackhouses, freakhouses)/curb side. The appeal of legitimate jobs as alternatives to crack distribution has been both very weak and very urgent. It depended on the stage in the developmental cycle.

Users and effects have also changed over the course of the epidemic. At first, smoking cocaine was an expensive luxury, and its use was restricted to affluent persons who did not find it instantly addictive. Later, when it had been adopted by a less affluent and more heterogeneous population, and one, moreover, that exhibited high consumption periodicities in regard to other (legal and illegal) commodities, variable effects were experienced, including compulsion and binging. The habit, at five years of age, of running ecstatically at very frequent intervals to the corner store to buy junk food (potato chips, candy, and artificial juices for 25 cents, representing a 1500% markup, much more than for any drug ever sold) had been turned, at 23 years of age, into the habit of running to the crack spot for another type of junk. Today, many users and abusers have simply given up smoking cocaine, even without the benefit of professional help; its appeal has faded for them. While the pharmacology of the drug and the physiology (or mental health status) of its users remained constant, shifting social identities or economic contexts (including the movement of cocaine prices and the conditions of supply) appear to be the stronger determinants of the drug’s variable effects.

How Do Drug Epidemics Succeed One Another? Implications for Policy

A further lesson, a corollary of the foregoing, is that policy ought to be flexible. For example, while there may have been some meaning in 1987 to the popular erroneous impression that crack use would entrap all of America or that neighborhoods had been invaded by crack and needed to be reclaimed, it makes little sense in 1991, when crack abusers are licking old wounds in indoor retreats (freakhouses where distribution is forbidden) or when crack distributors have been reduced both in number and substance. A “kinder, gentler America” certainly seems more affordable today.

Recognition that crack is in the final stage of the developmental cycle of a drug epidemic also identifies a number of absolutely urgent research tasks. What caused the use and abuse of crack to turn off, to become unattractive to potential experimenters? How is a new cycle generated and what will the new drug be — if it will be a drug? Answering such questions at this time (and providing fewer disheartened crack abusers with support and care) may be the only effective response to the drug problem. Especially to be feared today is untutored experimentation with other drugs. The example of the 1964-1972 heroin injectors who were introduced earlier is instructive. They had reached the same stage of frustration with heroin in 1971 that cocaine smokers are today experiencing with crack. Veins had collapsed and there was not one left intact into which to inject heroin, even if it had been offered free of charge. Craving treatment and care for health-related problems, heroin injectors were offered methadone. Unhappiness with methadone led to heavy drinking and eventually, by 1979, to injecting cocaine. In 1981, heroin-injectors turned cocaine-injectors via methadone complained that injecting cocaine was making them freeze up; they believed that soon they would be too frozen up to bleed. Presently, they began smoking cocaine (as freebase) and when this method of administering the drug proved acceptable to marijuana smokers, who were at the time suffering shortages of that drug, the first stage of the cocaine-smoking epidemic was set (Hamid 1992d).
The idea of a developmental cycle of drug epidemics, incorporating six distinct stages — onset, incubation, widespread diffusion, peak, decline, and stabilization — is a reminder that the dangers and opportunities of the drug are different from stage to stage, and should be met by policy that is sensitive to change. Perhaps the most critical stage is the one in which crack is now. At this point, apparently, policy can be the most effective factor in the cycle, in terms of providing safeguards against future epidemics. It is unfortunate that so far policymakers in the United States have not been not guided by this concept and its implications.

NOTES

1. Cocaine has been used in a variety of forms in this country and in Europe since the 1880s. It was administered in pills, wines, gums, tisanes, unguents, cigarettes, and cheroots (Martindale 1886; Parke Davis & Company 1886). The earliest mention of smokable cocaine in the present author’s fieldnotes dates back to 1940. An informant, now deceased, said then it was called “small-base” and was smoked in cigarettes; it gave a “cheeto high.”

2. Rastafarians are followers of a religiopolitical movement that originated in Jamaica in the 1930s, and later captivated the Caribbean in the 1970s. Its ideology stresses reliance on indigenous capital, talents, skills, and labor (Hamid 1992d, 1989). Marijuana distributors found it an excellent vehicle for expressing their feelings and ambitions.

3. It is widely believed that the word “crack” derives from the crackling sound cocaine oils make when being heated in the stem of a water pipe. In California, the fuller expression “crack-rock” is used, and distributors in New York have explained to Curtis (1990) that it derives from their having to crack up big cakes of rock or freebase for packaging in vials. The word was coined in 1984-1985 when distributors had started doing just that. Crack signifies separation of use from sales and marks the determination distributors had to separate themselves from their clientele by offering a prepared, prepackaged item. Crack also marks the emergence of cartels in Colombia, whose efforts quadrupled the production and export of cocaine and lowered street prices.

ACKNOWLEDGEMENTS

The author gratefully acknowledges the assistance of Bruce Johnson, Eloise Dunlap, Ali Manwar, Ric Curtis, Lisa Maher, Earl Beddow, Linda John, and Rahal Hamid.

REFERENCES


Drucker, E. 1990. Personal communication. Director, Social Medicine, Montefiore Hospital, Bronx, New York.


Parke, Davis & Company. 1886. Coca Erythroxylon and Its Derivatives.

Detroit: Scientific Department of Parke, Davis & Company.


