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## Criminal Activity Among Young Adults in the Club Scene

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The modern all-night dance club culture has its most recent roots in the adolescent rave and gay male circuit party subcultures that emerged in the late 1980s, with more distant connections to the earlier New York nightclub scene epitomized by Studio 54 (Fritz, 1999; Kurtz, Inciardi, Surratt, & Cottler, 2005; Silcott, 1999; Thornton, 1996). This type of night life is found in almost every large city but is especially prevalent in major tourist destinations where people tend to be looking for an escape from their routines. This concept is represented in such slogans as “What Happens in Vegas Stays in Vegas<sup>®</sup>.” Miami, historically a major tourist destination and since the early 1970s a national center for cocaine importation, distribution, and use (Didion, 1987; Portes & Stepick, 1993), is also a major player in the U.S. club culture.

Alcohol and illicit drug use would appear to be the norm in the club scene. Except for MDMA (ecstasy), which has been a relative constant, the most common “club” or “dance” drugs have tended to vary over time and location. Such diverse substances as powder cocaine, methamphetamine, ketamine, rohypnol, GHB, and LSD have all been popular in the club scene over the past decade (Beck & Rosenbaum, 1994; Measham, Aldridge, & Parker, 2001; Reynolds, 1998; Thornton, 1996). More recently, prescription medications, primarily opioids and benzodiazepines, have become prevalent as well (Kelly & Parsons, 2007; Kurtz et al., 2005).

One of the attractions to these drugs among the young adults who predominate in the club scene is the increased stamina that the substances engender, enabling participants to dance all night, as well as the intoxicating and sometimes hallucinogenic highs that are said to deepen the club or dance experience. Other reasons include the euphoric and disinhibiting effects of the drugs (Cooper, 2007; Fritz, 1999; Silcott, 1999). The drugs, like other aspects of the club culture, are usually portrayed as the height of fashion, exclusivity, and trendiness, and this reputation is maintained by the ubiquitous velvet rope at the nightclub entrance, with long lines of anxious attendees hoping to be admitted by the discriminating doorman.

Due to the young age of the vast majority of club drug users and their tendency to mix numerous drugs during their typical drug binges, club drug users tend to be a highly vulnerable population (Cottler, Womack, Compton, & Ben Abdallah, 2001; Boyd, McCabe, & d'Arcy, 2003; Freese, Miotto, & Reback, 2002). Many users tend to experiment with a variety of club drugs and alcohol in combination, which can lead to unexpected adverse

reactions (Measham et al., 2001; Pedersen & Skrondal, 1999; von Sydow, Lieb, Pfister, Höfler, & Wittchen, 2002). Other studies have reported club drug use to be associated with high-risk sexual behaviors (Klitzman, Greenberg, Pollack, & Dolezal, 2002; Mattison, Ross, Wolfson, & Franklin, 2001; Semple, Patterson, & Grant, 2002) as well as depression, anxiety, and other mental health problems (McCardle, Luebbers, Carter, Croft, & Stough, 2004; Measham et al., 2001; Parrott, Milani, Parmar, & Turner, 2001).

A large body of research from the past several decades demonstrates a strong relationship between drug use and crime (Ball, Rosen, Flueck, & Nurco, 1982; Inciardi, 2008). Offenders may become caught up in lifestyles that involve deviant activities on a daily or near-daily basis. Drug dependency may lead to economic crimes such as the commission of property and/or predatory crime and drug distribution. The pharmacological effects of drug use may also lead to criminal activity due to increased aggressive tendencies, reduced inhibitions, and impaired judgment (Goldstein, 1985).

Information about the criminal activity of participants in the club culture is largely absent from the scientific literature, however. Certainly, nightclub owners and promoters have been implicated in organized crime and other forms of drug-related and other violent crime (Cooper, 2007; Owen, 2003; St. James, 2003). Except for their use of illegal drugs, however, the young adult participants in the scene are most often described as targets of police harassment or victims of predatory criminals in the street environments surrounding the clubs (Measham et al., 2001) rather than as perpetrators. This study aims to add to our understanding of criminal activity among these participants in the club scene by examining the self-reported lifetime arrest histories of polydrug users in Miami's club culture.

## Methods

### Site

Miami/Dade County, Florida, is an extraordinarily diverse community of 2.4 million people with large numbers of foreign-born (45.1%) residents (U.S. Census Bureau, 2000). Hispanics (57.3%) are the largest ethnic group, with “Anglos” (the local term for non-Hispanic whites) representing 20.7% and African Americans/Caribbeans representing 20.0% of the county population. With the restoration of the South Beach art deco districts, Miami has become a national and international destination for partying, sexual tourism, and club drug use. To a great extent, South Beach has also become an East Coast center for the club culture—setting trends that are emulated and replicated elsewhere in the United States, Western Europe, and Latin America (Guzman, 1999; Kilborn, 2000; Marr, 2004; Schwartz, 2003; Shister, 1999). As one club promoter put it, “Every night is like New Year's Eve on South Beach, and drugs and sex are all part of it” (“The Price of Ecstasy,” 2004). Miami has also been designated by the Drug Enforcement Administration (DEA) as a destination where large amounts of prescription drugs are regularly being channeled into the illegal marketplace (U.S. DEA, 2004). As described earlier, a recent trend in this regard has been a significant incursion of prescription drugs into the club culture.

### Sampling Plan

Data are drawn from a natural history study of 601 participants in Miami's club scene who use club drugs and also use prescription drugs for nonmedical reasons. The major goals of the project are to examine the onset and progression of club and prescription drug abuse and to assess changes in health and social consequences of this abuse over time. Participants are interviewed at baseline and at three successive six-month intervals; data reported here are from baseline interviews.

To be eligible, participants must be 18 to 49 years old; willing to provide contact information, including a residential address and telephone number for scheduling follow-up appointments; and have used one or more club drugs at least three times during the past 90 days, have used one or more psychoactive prescription medications three times or more in the past 90 days for nonprescribed reasons, and reported regularly attending recognized local nightclubs at least twice per month. Club drugs were defined to include powder cocaine, ecstasy, GHB, ketamine, and LSD. The participants described in this report entered the study between May 2006 and June 2008.

Participants were recruited through respondent-driven sampling (RDS) (Heckathorn, 1997), a form of chain referral sampling that aims to minimize the potential sampling bias attributable to narrow social networks. In this study, each respondent/recruiter was limited to five coupons in order to prevent a few recruiters with large social networks from biasing the overall sample toward those with similar demographic and drug using profiles. RDS has been shown to quickly reduce sources of respondent bias (such as ethnic and sexual identity, gender, and drug of choice) as successive branches or waves of respondent contacts are enrolled and then solicited for additional contacts (Heckathorn, 1997, 2002).

### Field Operations

The project is housed in a field office strategically located to facilitate access to a diverse population of club and prescription drug users. This site is central to the hubs of nightclub activity and is easily reachable by public transportation, automobile, bicycle, or on foot by respondents from throughout the county. Private offices are used for all interviews. All field staff completed the requirements for National Institutes of Health (NIH) Web-based certification for protection of human subjects. Human subject protocols were approved by the University of Delaware's Institutional Review Board.

Interview data were collected using laptop computer-assisted personal interviews (CAPI). Clients received HIV education literature, condoms, and a \$50 stipend upon completion of the baseline interview, which lasted about two hours. These interviews assess life histories of alcohol and drug abuse, the extent of current drug use and impairment of daily activities, sexual risk-taking, social support, treatment histories, and physical and mental health problems, as well as criminal activity and arrest history.

### Measures

The *Global Appraisal of Individual Needs–Initial (GAIN-I)*, Version 5.4 (Dennis, Titus, White, Unsicker, & Hodgkins, 2002) was the primary component of the standardized baseline assessment. In addition to the collection of demographic, life history, and social risk data, the *GAIN-I* includes DSM-IVR diagnostics for substance abuse and dependence as well as clinical measures of depression, anxiety, and other mental health problems. The primary dependent variables for this report were lifetime arrest histories by type of crime. This item was assessed by the question, “How many times in your lifetime have you been arrested, charged with a crime, and booked?” followed by an itemization of the charges for each reported arrest. Subcategories were then created for property, violent, and alcohol/drug related crimes; it should be noted that the instrumentation did not distinguish drug possession from drug distribution arrests. Parole violations and other offenses, such as prostitution, mischief, trespassing, lewdness, and driving without a license were combined as “other” types of crime but were not separately analyzed.

To the extent possible, hypothesized predictors of arrest were also assessed using lifetime historical measures (e.g., “How many times in your life have you received treatment for your use of alcohol or any drug?”). Clinical measures of mental health problems reflect

symptoms experienced in the year prior to the baseline interview. Substance use data were collected using lifetime and 90-day measures; 90-day use data are reported in the tables to describe the sample, whereas lifetime use measures are included in regression models to predict lifetime arrests. Measures of lifetime use of the most commonly abused substances were dichotomized into “high lifetime use” and “not high lifetime use” categories based on the reported number of days each respondent used that substance in his or her lifetime, using the nearest round number to the median as the cutoff point. These rounded numbers were chosen because they were reported with high frequency and thus created natural cutoff points. For example, the range of days' lifetime MDMA use was 0 to 4,000 days, with a median of 82 days. The chosen cutoff point for “high lifetime use” was 100 days because of the proximity to the median and the relatively large frequency of reports ( $n = 21$ ) of exactly 100 days' lifetime use. No difference in outcomes resulted from using the exact or rounded median estimates.

Data from the interview questionnaires were analyzed using a standard statistical package. Descriptive statistics were calculated to describe the sample in terms of demographics, social stability, mental health, victimization, and substance use as well as to investigate the nature and extent of the participants' arrest histories. Bivariate logistic regression models were developed to predict lifetime arrest by crime category (i.e., property, violent, drug, and status crimes) by demographics and by hypothesized predictors, including substance use, mental distress, and victimization.

## Results

### Demographics, Social Stability, Mental Health, and Victimization

Demographics, social stability, mental health, and victimization characteristics of the sample are shown in Table 1. The ethnic mix of South Florida's population was fully represented in the sample. Few (17.3%) respondents had less than a high school or equivalent level of education, and the young median age of the sample (24 years) would indicate that many have a high potential for additional formal education. A sizeable number (42.6%) of respondents were still living with their parents. Only a small minority (14.8%) resided in Miami's impoverished urban core.

Social risk indices were high, with 43.8% reporting prior substance abuse treatment and more than two-thirds (67.2%) having been arrested. Depression, anxiety, and traumatic stress levels were clinically significant for sizeable proportions of respondents. Almost three-quarters (73.9%) of the participants met DSM-IVR diagnostic criteria for substance dependence in the past year. Lifetime rates of emotional, physical, and sexual victimization were very high as well, and almost two-thirds (63.4%) reported that the first episode of abuse occurred when they were minors. More than one-quarter (25.6%) of the respondents were *currently* worried about being abused (data not shown).

### Substance Use

Table 2 shows current (past 90 days) substance use behaviors. The extent of polydrug use was most striking as the majority of respondents (62.7%) used alcohol, marijuana, powder cocaine, MDMA, and prescription sedatives all within the past 90 days. Almost one-third (29.6%) of the sample reported current use of at least seven and as many as 13 different categories of substances. The sample reported being high or drunk all day on an average of 40 of the past 90 days (data not shown). Injection drug use was relatively rare.

## Arrest Histories

Arrest histories by type of crime are shown in Table 3. The distribution of crimes was widespread across all categories, including property and violent crimes in addition to the drug violations that would be expected given the study's eligibility criteria. Property crimes were primarily related to aspects of theft rather than destruction. Violent crimes were somewhat less common but were reported by almost one-quarter (24.8%) of the sample. Of the 404 participants with arrest histories, just 91 (22.5%) had been arrested only once, 75 (18.6%) two times, and a majority (58.9%) three or more times (data not shown).

## Predictors of Arrest Histories

Results of bivariate logistic regression models predicting arrest histories by type of crime are shown in Table 4, with the significance level set at  $p < 0.05$ . Most of the hypothesized mental health and social risk indices are significant in the models, with male gender; histories of substance abuse treatment, physical abuse, and childhood victimization; and heavy lifetime use of cocaine and marijuana demonstrating the most powerful effects across all types of crimes. Fewer years of education, severe clinical symptoms of traumatic stress, and high lifetime abuse of MDMA and prescription sedatives were important predictors of arrest for violent and property crimes but not for drug-related offenses. Residence in the high poverty urban core was associated only with arrests for violent crimes. Residing with parents was protective for violence- and drug-related arrests.

## Discussion

The participants in this study were for the most part suburban and well-educated, with many still living at home with their parents. Few resided in the urban areas typically associated with prevalent drug use and criminal activity. This was not unexpected given that nightclub attendance in Miami is an expensive form of entertainment, taking into account entrance fees, alcohol and drug expenses, clothing, and transportation. The arrest histories reported by the sample were more common and more varied than anticipated, however. Although drug-related arrests would be expected among substance users (and it was not possible to distinguish drug possession from drug distribution charges), there are no data in the literature that would point to the high prevalence of property and violent crimes among the sample of young adults found here. Furthermore, it was quite common for respondents to have been arrested for *multiple types* of crime.

Given their relatively high residential stability and educational attainment, the extent of the substance use, mental distress, and victimization histories reported by the study participants sample were equally surprising. These risk factors, including extensive lifetime drug abuse, prior treatment histories, and very high levels of victimization that occurred during childhood or adolescence, were strong predictors of criminal arrest. The high vulnerability to criminal activity as well as a wide variety of health and social problems of this population would appear to be largely overlooked in the literature.

This raises an important question about whether the vast majority of drug-related crime is in fact concentrated in stereotypical poor, ethnic, urban neighborhoods or whether young adult drug users who live in better neighborhoods may be underreported in crime statistics. One interpretation of the results is that young adult polydrug abusers in the club culture remain under the radar of criminal justice surveillance systems and researchers because they are perceived to be less vulnerable—and perhaps less threatening to society—than street-based criminals. Another would be that cities that rely on nightclub activity to support tourism and other economic activity tend to look the other way in regards to drug activity and the other social problems associated with the scene.

In any case, this population of young adult substance abusers appears to be in great need of outreach for mental health and substance abuse treatment services. Participation in the club scene by the very young should also be understood as a likely marker for past violent, emotional, and sexual victimization that may lead to other health and social problems. Longitudinal research, including the ongoing follow-up assessments of the participants in this study, will provide a better understanding of the extent to which some young adults in the club scene may “age out” of the scene and reduce their associated health and social risk behaviors without intervention. Given the broad extent of the problems illuminated here, this would appear to be less likely than may be widely assumed.

There are two primary limitations to the study. First, the results are likely not generalizable to the overall population of participants in the club culture in Miami because of the eligibility requirements that included current abuse of both club drugs and prescription medications. These requirements likely produced an especially high risk sample. As well, many of the respondents may have been attracted to participate because of the monetary compensation provided, perhaps skewing the sample toward the lower economic strata of people in the scene. Nevertheless, the RDS procedures employed resulted in a diverse sample that would appear to be representative of the population given these eligibility requirements and the likely exclusion of high-income persons. Finally, the data presented rely on self-report, and some respondents may have refrained from reporting the full extent of socially undesirable behaviors. Given the extensive substance abuse and arrest histories described, however, underreporting of these and other stigmatized behaviors would seem less likely.

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## Biographies

**Steven P. Kurtz**, PhD, Sociology, is a scientist with the Center for Drug and Alcohol Studies at the University of Delaware. He serves as Co-principal investigator and project director for a National Institute on Drug Abuse (NIDA)-funded natural history study of prescription drug abuse in Miami's club culture. He is also principal investigator of a NIDA-funded five-year clinical trial of a novel risk reduction intervention for high-risk gay men. Dr. Kurtz has conducted research studies regarding substance abuse, sexual risk behaviors, related health and social problems, and intervention approaches among young adults, adolescents, men who have sex with men, and other vulnerable populations since 1995.

**James A. Inciardi**, PhD, is the director of the Center for Drug and Alcohol Studies at the University of Delaware; professor in the Department of Sociology and Criminal Justice at Delaware; adjunct professor in the Department of Epidemiology and Public Health at the University of Miami School of Medicine; and a guest professor in the Department of Psychiatry at the Federal University of Rio Grande do Sul in Porto Alegre, Brazil. Dr. Inciardi's research career spans almost four decades and includes numerous studies of substance abuse treatment among offender populations, HIV epidemiology and prevention, and prescription drug abuse and diversion. He is the author of more than 450 articles, chapters, and books in the areas of substance abuse, criminology, criminal justice, history, folklore, public policy, HIV/AIDS, medicine, and law.

**Elisa Pujals**, MPH, was awarded her graduate degree, specializing in Global Health Promotion, from George Washington University in 1994. She served as a research associate at the Center for Drug and Alcohol Studies at the University of Delaware for several years until her relocation to Puerto Rico in July 2008.

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**Table 1**  
**Demographic, Social Stability, Mental Health, and Victimization Characteristics of**  
**Substance Using Participants in Miami's Club Scene (N = 601)**

	<i>n</i>	%
<b>Demographics</b>		
Age (median years)	24	
Gender		
Male	355	59.1
Female	243	40.4
Transgender	3	0.5
Race/ethnicity		
African American	152	25.3
Hispanic	303	50.4
White/Anglo	126	21.0
Other	20	3.3
Live with parents	256	42.6
Live in high poverty urban zone	89	14.8
Less than high school education	104	17.3
<b>Social Stability (Lifetime)</b>		
Substance abuse treatment history	263	43.8
Arrest history	404	67.2
3 or more lifetime arrests	238	39.6
<b>Mental Health (Past Year)</b>		
Moderate/severe depression	376	62.6
Moderate/severe anxiety	298	49.6
Moderate/severe traumatic stress	351	58.4
DSM-IV substance dependence	486	73.9
<b>Victimization History (Lifetime)</b>		
Sexual abuse	107	17.8
Physical abuse	392	65.2
Emotional abuse	320	53.2
First abuse before age 18	381	63.4

**Table 2**  
**Past 90-Day Substance Use Characteristics of Participants in Miami's Club Scene (N = 601)**

<b>Substance Use</b>	<b><i>n</i></b>	<b>%</b>
Alcohol	591	98.3
Marijuana	560	93.2
Powder cocaine	542	90.2
Crack cocaine	83	13.8
MDMA (ecstasy)	498	82.9
Methamphetamine	51	8.5
LSD	112	18.6
Psilocybin (mushrooms)	75	12.5
Ketamine	41	6.8
GHB	22	3.7
Heroin	45	7.5
Rx opioids (nonprescribed)	358	59.6
Rx sedatives (nonprescribed)	527	87.7
Rx stimulants (nonprescribed)	49	8.2
Injection drug use	38	13.0

**Table 3**  
**Lifetime Arrest Histories—by Major Crime Category and Significant Subcategories—of**  
**Substance Using Participants in Miami's Club Scene (N = 601)<sup>1</sup>**

	<i>n</i>	%
<b>Property Crimes</b>	<b>180</b>	<b>30.0</b>
Larceny/theft	72	12.0
Shoplifting	52	8.7
Burglary	73	12.1
Stolen goods	22	3.7
Motor vehicle theft	45	7.5
Vandalism	29	4.8
Passing checks/forgery	20	3.3
Arson	8	1.3
<b>Violent Crimes</b>	<b>149</b>	<b>24.8</b>
Aggravated assault	52	8.7
Simple assault/battery	91	15.1
Robbery	50	8.3
Homicide	7	1.2
Rape	1	0.2
<b>Drug/Alcohol Crimes</b>	<b>270</b>	<b>44.9</b>
Possession/distribution of drugs	238	39.6
Driving under the influence	39	6.5
Drunkenness	34	5.7
<b>Other Offenses</b>	<b>188</b>	<b>31.3</b>

<sup>1</sup> Respondents reporting arrests for different categories of crime and different crimes within categories do not add to 100% because many respondents reported arrests for multiple crimes.

**Table 4**  
**Predictors of Arrest History by Type of Crime Among Substance Using Participants in Miami's Club Scene**

Bivariate Models <sup>1</sup>	Violent Crimes (n = 149) Odds Ratio (CI) p	Property Crimes (n = 180) Odds Ratio (CI) p	Drug Crimes (n = 270) Odds Ratio (CI) p
<b>Demographics<sup>1</sup></b>			
Male	2.383 (1.582, 3.589)	1.758 (1.217, 2.540)	4.341 (3.034, 6.213)
Live with parents	0.655 (0.446, 0.962)	0.031	0.683 (0.492, 0.948)
Live in high poverty zone	2.129 (1.323, 3.424)	0.002	ns
Less than high school education	1.794 (1.138, 2.829)	0.012	0.039
<b>Social Stability</b>			
Substance abuse treatment history	1.900 (1.307, 2.762)	0.001	0.000
<b>Mental Health</b>			
Severe traumatic stress	1.512 (1.040, 2.198)	0.030	0.045
<b>Victimization</b>			
Physical abuse history	2.353 (1.524, 3.633)	0.000	0.000
First abuse before 18	2.117 (1.396, 3.209)	0.000	0.000
<b>High Lifetime Substance Use</b>			
Alcohol <sup>2</sup>		ns	1.484 (1.039, 2.119)
Marijuana <sup>3</sup>	1.648 (1.132, 2.398)	0.009	2.131 (1.489, 3.049)
Powder cocaine <sup>4</sup>	1.544 (1.063, 2.243)	0.023	2.313 (1.614, 3.313)
MDMA (ecstasy) <sup>5</sup>	1.542 (1.063, 2.237)	0.023	1.611 (1.134, 2.289)
Rx sedatives <sup>6</sup>	1.570 (1.082, 2.278)	0.018	2.115 (1.483, 3.016)
Rx opioids <sup>5</sup>		ns	1.712 (1.194, 2.454)

<sup>1</sup> Nonsignificant predictors included depression, anxiety, substance dependence, sexual abuse, and emotional abuse.

<sup>2</sup> 1,000 days lifetime

<sup>3</sup> 2,000 days lifetime

<sup>4</sup> 400 days lifetime

<sup>5</sup> 100 days lifetime

<sup>6</sup> 200 days lifetime