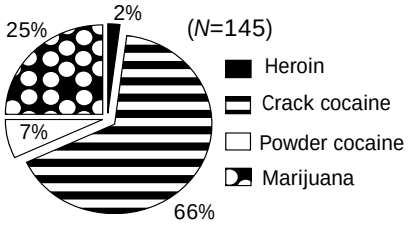
ATLANTA METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 4,112,198
- Median age: . . . . . 32.9 years
- Race (alone):
  - White 64.2%
  - Black 29.6%
  - American Indian/ Alaska Native 0.7%
  - Asian/Pacific Islander 3.8%
  - Other race 3.6%
  - Two or more races 1.7%
- Hispanic (of any race): . . . 6.5%
- Unemployment rate: 3.5%
- Median household income: $51,948
- Families below poverty level with children <18 years: 11.8%

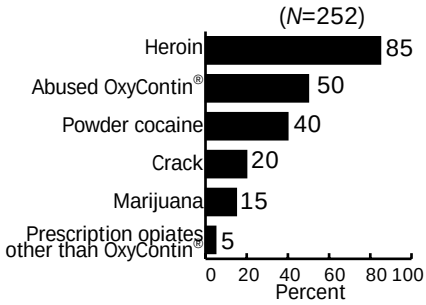
*Source: U.S. Census 2000**

What are the primary drugs of abuse among clients in a non-methadone treatment program? (Fall 2002)



Source: Non-methadone treatment respondent

What drugs do clients in a methadone program abuse+? (Fall 2002)



+Includes any use, whether as a primary, secondary, or tertiary drug; responses for methamphetamine and ecstasy were "very small."

Source: Methadone treatment respondent

THE BIG PICTURE: WHAT'S CHANGED? (SPRING 2002 VS FALL 2002)

Three[L,N,M] of four *Pulse Check* respondents believe the city's overall drug problem is very serious and stable, and one believes it is somewhat serious but somewhat worse.[E]

Respondents report several changes in Atlanta's drug abuse scene:

- South American heroin, the most common form available, became more difficult for undercover officers to buy.[E]
- Tuberculosis cases among methadone clients, although somewhat high in Atlanta compared with other cities, decreased due to increased surveillance and treatment.[N,M]
- Shoplifting in order to obtain goods or cash to be exchanged for cocaine declined over the past 10 years due to increased law enforcement.[N]
- Although hepatitis C diagnoses are increasing, they may be due to increased awareness and testing for the disease.[N]
- In general, heroin use increased; however, the number of new heroin users declined.[E]
- Opiate-related overdoses increased, perhaps because OxyContin® (oxycodone controlled-release) abusers often switch to heroin and then overdose.[M]
- Heroin is often cut with diverted OxyContin® or powder cocaine—both new phenomena.[M]
- OxyContin® abuse among methadone treatment admissions increased slightly, and 50 percent of all methadone admissions now abuse the drug.[M]
- Marijuana use in general increased slightly;[E] however, marijuana use among non-methadone treatment admissions declined.[N]
- All forms of methamphetamine (including ice) are less difficult to buy.[L,E] The increased supply and availability of methamphetamine may be related to the decreased supply of cocaine.[L]
- As reported in several other *Pulse Check* cities, methamphetamine use increased dramatically. Its use increased at nightclubs and raves.[E]
- Locally based sellers of methamphetamine manufactured in small, local labs increased.[E]
- Methylenedioxymethamphetamine (MDMA or ecstasy) has been less difficult to buy as the supply increased.[L,E]
- Ecstasy use increased dramatically, as did the variety of use settings.[E]
- Independent dealers who sell locally pressed ecstasy tablets increased, and prices declined.[E]

Three sources agree that crack is the drug related to the most serious consequences.[L,E,N] The sources differ in their perception of which drug is most commonly abused.

- *Since spring 2002, crack has increased slightly as a primary drug among non-methadone treatment admissions while marijuana has declined slightly.*[N]
- *OxyContin® abuse among methadone treatment clients increased between spring and fall 2002.*[M] *One-fifth of the clients report it as a primary problem, and half of the clients report any use.*[M]

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

Most widely abused drug:
- Crack[L,N]
- Marijuana[E]
- Heroin[M]

No reported changes between spring and fall 2002[L,E,N,M]

Second most widely abused drug:
- Crack[E,M]
- Ecstasy and methamphetamine[L]
- Marijuana[N]

No reported changes between spring and fall 2002[L,E,N,M]

Drug related to the most serious consequences:
- Crack[L,E,N]
- Heroin[M]

No reported changes between spring and fall 2002[L,E,N,M]

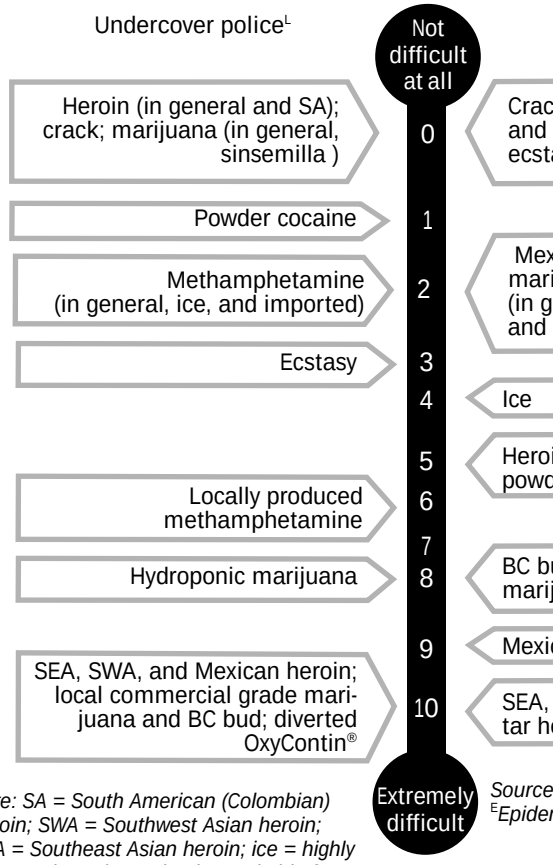
Drug related to the second most serious consequences:
- Methamphetamine[L]
- Heroin[E]
- Marijuana[N]
- Crack[M]

No reported changes between spring and fall 2002[L,E,N,M]

New or emerging problems:
- Ecstasy[L]
- Methamphetamine[E]
- OxyContin® abuse continues to increase[M]

Sources: [L]Law enforcement, [E]Epidemiologic/ ethnographic, [N]Non-methadone treatment, and [M]Methadone treatment respondents
Note: These symbols appear throughout this city profile to indicate type of respondent.

How difficult is it for undercover police and users to buy drugs? (Fall 2002)



Note: SA = South American (Colombian) heroin; SWA = Southwest Asian heroin; SEA = Southeast Asian heroin; ice = highly pure methamphetamine in smokable form; and BC bud= British Columbian marijuana

Sources: [L]Law enforcement respondent; [E]Epidemiologic/ ethnographic respondent

Some drugs were more difficult to buy between spring and fall 2002:
- *South American heroin*[L]
- *Crack and powder cocaine ("The supply has dwindled substantially since September 11, 2001."*[L]*)*

Two drugs were less difficult to buy since spring 2002:
- *Methamphetamine*[L,E] *(as reported by 10 other* Pulse Check *respondents in 8 other cities)*
- *Ecstasy*[L,E] *(as reported in New York and Pittsburgh)*

The law enforcement source believes that the increased methamphetamine supply may be due to the decreased cocaine supply, and the epidemiologic source notes that within a 6-month period, methamphetamine availability fluctuates rapidly.[E]

HEROIN

Heroin availability declined, but use increased:

- South American heroin, the most common form available in Atlanta, has become more difficult for undercover officers to buy between spring and fall 2002.[E]
- In general, heroin use increased; however, new heroin users declined.[E]

COCAINE

Three sources report crack as the drug relating to the most serious consequences, but most indicators show cocaine use and activity have declined:

- Crack and powder cocaine have become more difficult for undercover officers to buy between spring and fall 2002.[L]
- Crack cocaine use in general has declined since spring 2002;[E] however, crack cocaine non-methadone treatment admissions increased slightly.[N]
- Crack cocaine sales on college campuses increased between spring and fall 2002.[L]

MARIJUANA

Marijuana use in general increased slightly.[E] However, marijuana use among non-methadone treatment admissions declined.[N]

METHAMPHETAMINE

Nearly all reports point to increasing use and activity of the drug:

- All forms of methamphetamine (including ice) are less difficult to buy.[L,E] The increased supply and availability of methamphetamine may be related to the decreased supply of cocaine.[L]
- Methamphetamine use increased dramatically. Its use is more common at nightclubs and raves than it was in spring 2002.[E]
- New methamphetamine users increased. They often use the drug by heating it and, using a plastic tube, inhaling the vapor through the nose—a practice referred to as "hotrailing."[E]

MDMA (ECSTASY)

- Ecstasy became less difficult to buy between spring and fall 2002 as the supply increased.[L,E]
- Ecstasy use increased dramatically, the variety of use settings increased, and the drug is now used by Whites and Blacks equally.[E]
- Recent adulterants include ketamine, gamma hydroxybutyrate (GHB), methamphetamine, amphetamine, and dextromethorphan.[E]

ABUSED OXYCONTIN®

- Among methadone treatment admissions, primary OxyContin® abuse increased.[M]
- Opiate-related overdoses increased, perhaps because OxyContin® abusers often switch to heroin use and then overdose on heroin.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity

- The *Pulse Check* non-methadone treatment source is with a program that is nearly at full capacity (145 of 160 treatment slots filled). Crack remains the most common drug used, followed by marijuana. *(See pie chart on the first page of this chapter.)*
- The non-methadone treatment source notes that outpatient slots are available, but residential slots often are not, and capacity has declined due to funding cuts.[N]
- The methadone treatment source is with a private methadone center that is 84-percent full (252 of 300 treatment slots filled).[M] Although heroin remains the most common primary drug of abuse (at 75 percent), primary OxyContin® abusers constitute 20 percent of clients.[M] Furthermore, 50 percent of the clients in that program report either primary, secondary, or tertiary abuse of OxyContin.® *(See pie chart on the first page of this chapter.)*
- The methadone treatment source notes an increase in treatment demand not matched by increased treatment capacity.[M]

Negative health consequences of drug abuse

- HIV/AIDS, hepatitis C, and drug-related overdoses are the most common negative health consequences among methadone treatment admissions, and all three have increased since spring 2002.[M] HIV/AIDS may be rising due to increased injecting drug use; the apparent rise in hepatitis C is due to increases in injecting drug use and testing for the disease.
- Tuberculosis among methadone clients, although somewhat high in Atlanta compared with other cities, decreased between spring and fall 2002 due to increased surveillance and treatment.[N,M]
- HIV/AIDS among non-methadone treatment clients increased slightly due to more common heterosexual transmission among young adults.[N]
- Cardiovascular problems related to cocaine use are increasing because people are taking higher doses of cocaine.[N]
- High-risk pregnancies among non-methadone treatment clients (especially wealthier clients) are relatively common and detected more often because of increased testing.[N]
- The methadone source reports that the number of dually diagnosed clients increased in the past 10 years. These clients are difficult to refer to mental health centers because many do not take clients who are on methadone.[M]
- Mood disorders among treatment clients, which are the most common comorbid disorders, increased due to improved diagnostic techniques.[N,M]
- Antisocial or conduct disorders increased among methadone treatment clients and may be related to increased methamphetamine or OxyContin® abuse.[M]

Barriers to treatment

- Among non-methadone treatment clients, the most common barrier to treatment is inadequate housing during and after treatment. This problem has increased since spring

2002. "Atlanta is a homeless magnet, and many people emigrate here from other places."[N]

- Adolescent programs in Atlanta have been recently discontinued.[N]
- Medicaid has stopped providing transportation; thus, the non-methadone program offers less money for it now.[N]
- Violent behavior among presenting clients and lack of trained staff to treat comorbidity are uncommon problems and have further declined since spring 2002. The source reports more and better trained staff to treat comorbid illnesses.[N]
- The methadone treatment source claims that treatment cost is their number-one barrier and has increased as a problem since spring 2002.[M]
- Other common barriers to methadone treatment include limited slot capacity (an increasing problem due to higher demand for treatment), lack of transportation or money for transportation, cultural barriers among Hispanics (a problem that has grown as the Hispanic population has increased in Atlanta), and the social stigma of treatment (especially among OxyContin® abusers, who are typically new to treatment for any drug).[M]

Increased complications for drug treatment over the past 10 years

- Increasing availability of new drugs: The emergence of OxyContin® as a drug of abuse has made it much more difficult to treat clients.[M]
- More polydrug use: Both treatment respondents report polydrug use (crack and powder cocaine and marijuana among non-methadone clients; and heroin, cocaine, marijuana, and benzodiazepines among methadone clients) as increasing steadily in the past 10 years.[N,M]
- Lack of housing, jobs, and job training opportunities for recovering clients: Treatment respondents agree that resources for recovering clients have declined in the past 10 years and especially in the past 2 years.[N,M]

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to describe any emerging user groups and to report on how the drugs are used. As shown on the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different populations and use patterns for each drug. For example, all methadone clients are primary opiate users who may use drugs other than opiates in a secondary or tertiary manner.

Who's most likely to use cocaine?

	Crack			Powder cocaine		
Characteristic	E	N	M	E	N	M
Age group (years)	>30	>18	>30	>30	>30	>30
Mean age (years)	32	30	NR	30	NR	NR
Gender	Split evenly	60% male	Split evenly	60% male	Split evenly	60% male
Race/ethnicity	Black	White	Black	White and Black	Black	Black
Socioeconomic status	Low	Low	Low	Low and middle	Low	Low
Residence	Central city	Central city	Central city	Central city and suburbs	Central city	Central city
Referral source	N/A	Criminal justice	Individual	N/A	Individual	Individual
Level of education completed	N/A	High school	High school	N/A	High school	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Part time	Part time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Crack cocaine ("pop" or "rock") use declined between spring and fall 2002[E]; however, crack cocaine non-methadone treatment admissions increased somewhat over the same time period.*
- *Smoking crack in combination with marijuana is a common practice.[E,N]*
- *Among new powder cocaine users, use increased somewhat since spring 2002.[E] These new users are more likely than the general powder cocaine-using population to be Black young adults of low-middle socioeconomic status who live in the central city. The new users often smoke powder cocaine in combination with marijuana.[E]*

- *In general, heroin use increased between spring and fall 2002.*[E]
- *Sources agree that most heroin ("boy," "little boy," and "mac") users are males older than 30 of low socioeconomic status who live in the central city.*[E,N,M]
- *New heroin users, who declined in number since spring 2002, are more likely than the general heroin-using population to be White young adults of middle socioeconomic status who snort the drug.*[E]

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	32	NR	NR
Gender	80% male	Male	62% male
Race/ethnicity	Black	Black	White
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Individual	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Full and part time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball)	Powder or crack cocaine (speedball)	Crack cocaine or benzodiazepines (in combination)
Publicly or privately?	Privately	Publicly	Privately
Alone or in groups?	Both	Alone	Alone

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; Methadone treatment respondent

- *Sources agree that injecting is the most common route of heroin administration in Atlanta.*[E,N,M]
- *Cocaine is often injected with heroin as a speedball.*[E,N,M]
- *Sources report no changes in use characteristics.*

- *Marijuana use in general increased slightly since spring 2002;*[E] *however, marijuana use among non-methadone treatment admissions declined.*[N]
- *Marijuana is often smoked in joints, blunts, and pipes.*[E,N,M]
- *Respondents report no changes in marijuana user and use characteristics between spring and fall 2002.*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–30	18–30	>18
Mean age (years)	18	NR	NR
Gender	60% male	60% male	70% male
Race/ethnicity	White and Black	Black	White
Socioeconomic status	All	Low	Middle
Residence	All	Central city	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Full time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

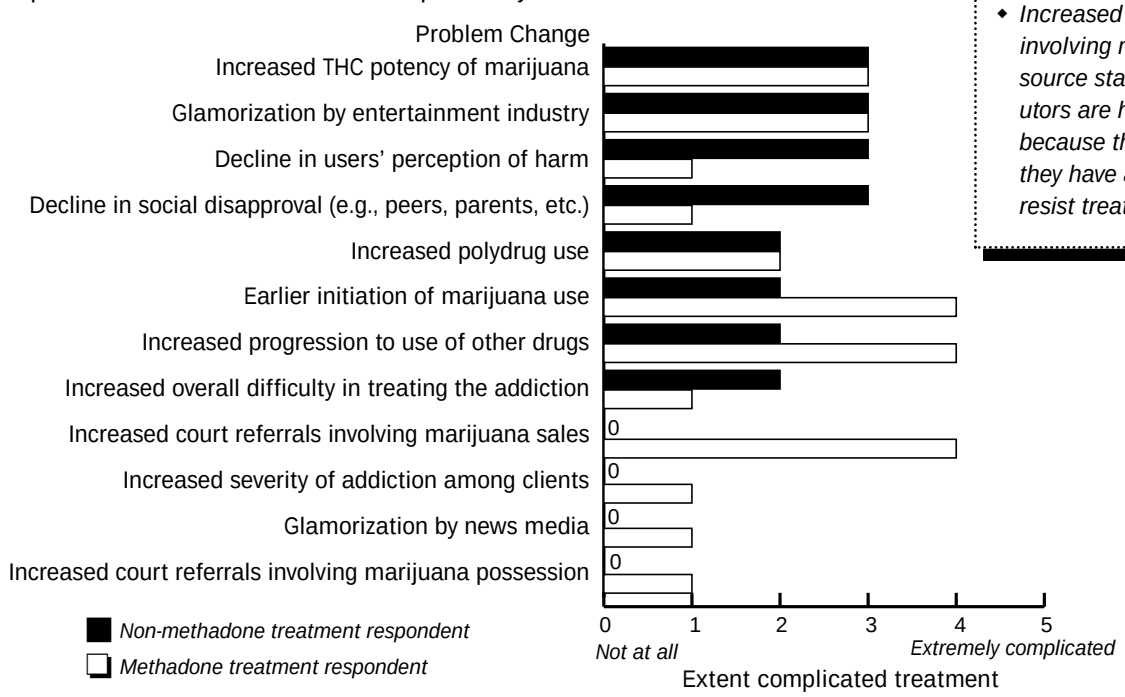
Marijuana, used either alone or with other drugs, is associated with the following consequences, which remained stable between spring and fall 2002:

- Drug-related arrests[N]
- Dropping out of school[N]
- Unemployment rates[N]
- Short-term memory loss[M]
- Poor workplace performance[M]

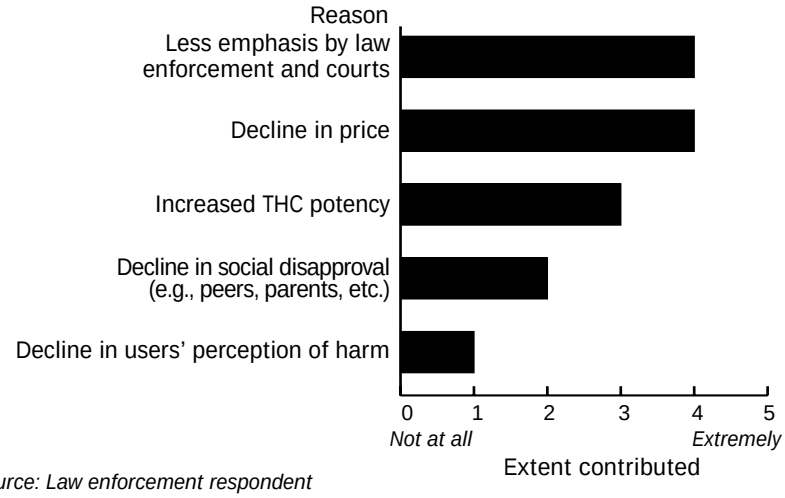
What they have to say...

- *Increased THC potency of marijuana: Rated as somewhat of a problem in treating marijuana clients, the increased potency of the drug has caused "greater dependence on marijuana" than it has in the past.*[N,M]
- *Increased court referrals involving marijuana sales: One source states that "drug distributors are harder to treat because they don't accept that they have a problem and often resist treatment."*[N]

Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



Widespread marijuana availability and use over the past 10 years: To what extent have the following contributed?



Source: Law enforcement respondent

What they have to say...

- *Less emphasis by law enforcement and courts and decline in the price of marijuana contribute most to increased marijuana activity.*[L]
- *THC potency has increased 7 percent over the past 10 years, which is seen as somewhat responsible for increased marijuana use.*[L]
- *The law enforcement source believes that indoor marijuana farms, promotion of marijuana as "medicine," and glamorization by the entertainment industry and news media are not related to increased marijuana activity.*

Who's most likely to use methamphetamine, and how do they take the drug?

Characteristic	E
Age group (years)	13–30
Gender	Split evenly
Race/ethnicity	White
Socioeconomic status	Middle
Residence	Suburbs and rural areas
Primary route of administration	Snorting
Other drugs taken	Ecstasy (in combination and sequentially to "kick it up")
Publicly or privately?	Both
Alone or in groups?	Both

Source: [E]Epidemiologic/ethnographic respondent

- *Methamphetamine use in general increased dramatically since spring 2002.*[E]
- *Methamphetamine users tend to be White, 13–30 years old, and split equally between genders.*[E]
- *New methamphetamine users are younger than the general methamphetamine-using population (adolescents versus adolescents and young adults) and are more likely to use the drug publicly and in groups.*[E]
- *New methamphetamine users often heat the drug and, using a plastic tube, inhale the vapor through the nose—a practice referred to as "hotrailing."*[E]
- *The use of methamphetamine with ecstasy has increased, especially at nightclubs and raves.*[E]

Who's most likely to use ecstasy?

Characteristic	E
Age group (years)	13–30
Gender	60% male
Race/ethnicity	White and Black
Socioeconomic status	Middle
Residence	Suburbs

Source: [E]Epidemiologic/ethnographic respondent

- *Ecstasy use increased dramatically between spring and fall 2002.*[E]
- *Most ecstasy users are male adolescents and young adults who are equally likely to be White or Black.*[E]
- *Although ecstasy is most often used in public places, the epidemiologic source reports an increase in use in private residences and increased diversity in the places where people use the drug.*[E]

- *OxyContin® abuse among methadone treatment admissions increased somewhat since spring 2002. Half of all methadone admissions now abuse the drug.*[M]
- *OxyContin® abusers tend to be White adults older than 30 who live in the suburbs.*[E,M]
- *Oral administration is most common, and combining hydrocodone (Vicodin®) with OxyContin® is a common practice.*[M]

Who's most likely to abuse OxyContin®?

Characteristic	E	M
Age group (years)	>30	>30
Gender	NR	55% male
Race/ethnicity	White	White
Socioeconomic status	NR	Middle
Residence	Suburbs	Suburbs

Sources: [E]Epidemiologic/ethnographic respondent; [M]Methadone treatment respondent.

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin and crack cocaine are most often sold in central city areas, and powder cocaine, methamphetamine, and ecstasy are most often sold in central city and suburban areas.[L] Since spring 2002, methamphetamine and ecstasy sales increased in central city areas.[E]

Drug sales in Atlanta, excluding methamphetamine sales, often take place on streets and in open-air markets. Three known open-air drug markets exist in Atlanta neighborhoods: Pittsburgh, Mechanicsville Community, and Vine City ("The Bluff"). The number of buyers who go to the two former markets declined, but the open-air market in Vine City has become busier.

Along with open-air market sales, heroin sales occur in a variety of mostly public settings:

- Crack houses and shooting galleries[L,E]
- Public housing developments[L,E]
- Hotels/motels[L,E]
- Around shopping malls[L]
- Private residences[E]
- Around drug or alcohol treatment clinics[E]

Crack and marijuana are sold at all heroin sales locations plus the following:

- In or around schools[L,E]
- College campuses[L,E]
- Nightclubs and bars[L,E]
- Playgrounds and parks[L]
- Private parties[L,E]
- Raves[L,E]
- Concerts[L,E]
- Around supermarkets[L]
- Inside cars[L]
- Around drug or alcohol treatment clinics (excluding marijuana)[E]

Crack cocaine sales on college campuses increased between spring and fall 2002.[L]

Methamphetamine and ecstasy sales occur in more private settings than do heroin sales:

- Private residences[L,E]
- Nightclubs and bars[L,E]
- Private parties[L,E]
- Raves[E]
- Concerts[L,E]
- Hotels/motels[L]
- The Internet (excluding ecstasy)[E]

Additionally, ecstasy is sold around shopping malls, in or around schools,[L,E] and on college campuses.[E]

Use settings for the various drugs tend to mirror their sales settings. Between spring and fall 2002, one source notes two changes in use settings: methamphetamine use is now more common at nightclubs and raves, and ecstasy is used in a wider variety of settings.

HOW DO DRUGS GET FROM SELLER TO BUYER?

To purchase heroin, crack and powder cocaine, or marijuana, a buyer must know in what neighborhoods (open-air markets), public housing developments, or shopping malls drugs are available. The buyer goes to a known location and approaches a dealer openly for a hand-to-hand exchange of the drug.[L,E]

Along with out-in-the-open sales, powder cocaine and marijuana are often purchased via delivery: sellers may be involved with the same buyers for several years, and buyers contact dealers (via cell phones and e-mail) to set up a delivery to their private residences.[L,E]

In addition to street sales, marijuana is sold in some settings (college campuses and schools) via acquaintance networks. At certain venues (raves and concerts), buyers can "ask around" about where to purchase marijuana, and someone will direct them to a dealer for a hand-to-hand exchange of the drug.[L]

Methamphetamine sales are more private than other drug sales in Atlanta: a mutual acquaintance must introduce buyers to sellers to facilitate a sale, or a buyer must know a nightclub or bar where methamphetamine is sold.[L]

Ecstasy is sold in a variety of ways, including at open-air markets similar to heroin sales, and the following:

1. A buyer goes to a particular nightclub, bar, concert, or rave and "asks around" for the drug.[L,E]
2. Ecstasy dealers have private parties at private residences where the drug is sold and used.[L]
3. Buyers call their "regular" dealer to have the drug delivered.[E]

WHO SELLS HEROIN, CRACK AND POWDER COCAINE, AND MARIJUANA?

Most heroin, crack cocaine, and marijuana dealers (who often sell all three drugs) are young adults organized into loose-knit gangs whose members tend to live in the same neighborhoods and obtain drugs from the same supplier.[L] Many sales also involve "runners," adolescents who act as liaisons between sellers and buyers.[E]

Most powder cocaine dealers are adults older than 30 who are organized and connected to the trafficking organizations.[L]

WHO SELLS METHAMPHETAMINE AND ECSTASY?

Methamphetamine sellers are divided into two groups based on the type of methamphetamine sold:[E] (1) methamphetamine manufactured in large Mexican labs is sold by adults older than 30 whose organization is controlled by Mexican trafficking groups; (2) methamphetamine manufactured in small, local labs is sold by independent young adults, a group that increased since spring 2002.

Ecstasy dealers may be organized and affiliated with ecstasy traffickers, or else independents who sell locally pressed pills.[L,E] Independent dealers increased between spring and fall 2002.[E]

How pure are heroin, cocaine, and marijuana, and how much do they cost?

Drug	Unit	Purity	Price
South American heroin	"20 bag" One hit 1 g	>50% NR	$20[E] $30[L] $300[L]
Crack	One rock	NR	$5, $10, $20[L,E]
Powder cocaine	One bag	60%	$5[E]
Marijuana (commercial grade or sinsemilla)	Dime bag (2–3 g) 1 oz	NR NR	$10[L,E] $120[E]

Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

Most prices and purity levels remained stable between spring and fall 2002 with a few exceptions:

- *Heroin prices declined at all unit levels.*[L]
- *Heroin is often cut with OxyContin® or powder cocaine—both new phenomena since spring 2002.*[M]
- *Crack cocaine dealers often "run specials" such as two rocks for one on Sundays.*[E]

How much do methamphetamine and ecstasy cost?

Drug	Unit	Price
Methamphetamine (powder)	One hit	$10, $20[L]
Ecstasy	One pill	$15–$20[E]

Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

- *Methamphetamine purity is about 34 percent at most unit levels. Price and purity have remained relatively stable between spring and fall 2002.*[E]
- *Ecstasy prices have declined from $20–$25 to $15–$20 per pill. Recent adulterants include ketamine, GHB, methamphetamine, amphetamine, and dextromethorphan.*[E]

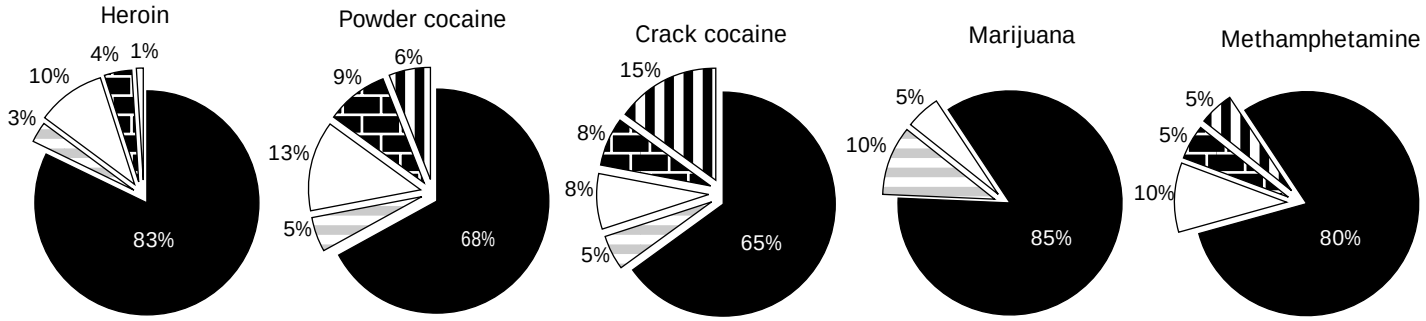
Which drug sellers are associated with which crimes?

Crime	Heroin	Powder cocaine	Crack cocaine	Marijuana	Metham-phetamine	Ecstasy
Prostitution			✓	✓		
Gang-related activity	✓	✓	✓		✓	
Violent criminal acts: robberies and burglaries	✓	✓	✓	✓	✓	
Nonviolent criminal acts: shoplifting	✓	✓	✓	✓	✓	✓
No other crimes associated		✓				✓

Sources: Law enforcement respondent; Epidemiologic/ethnographic respondent

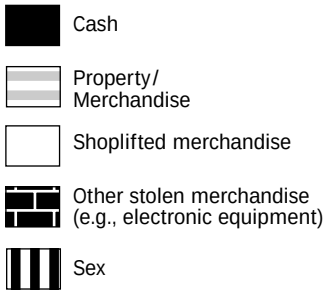
Drug dealers are associated with a wide variety of crimes in Atlanta, including robberies, burglaries, gang-related crimes, shoplifting, and prostitution.[L,E]

Beyond cash: What else is accepted in exchange for drugs?



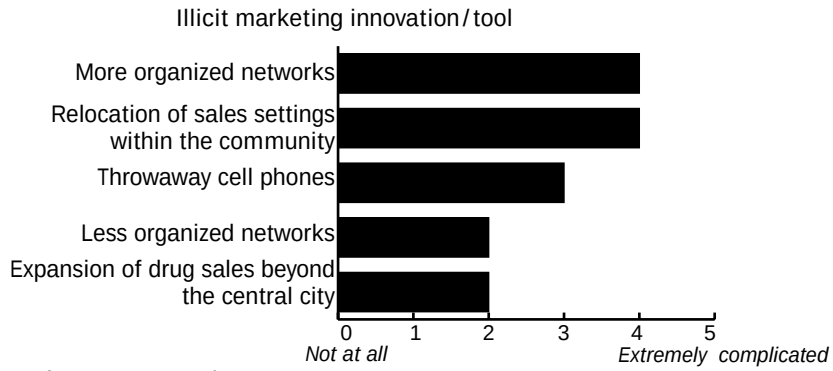
What they have to say...

- *Like in nearly all* Pulse Check *cities, cash remains the number-one means of exchange for drugs.*[N,M]
- *One source reports that sex in exchange for crack and powder cocaine increased over the past 10 years.*[N]
- *Although still accounting for nearly 10 percent of all cocaine exchanges, shoplifting as a mode of exchange declined over the past 10 years due to increased law enforcement.*[N]
- *As reported in several* Pulse Check *cities, food stamps are no longer used in exchange for drugs because people are not able to manipulate the new electronic version of food stamps.*[N]



Source: Mean of response ratings given by non-methadone and methadone treatment respondents. The non-methadone respondent did not provide information on methamphetamine exchanges.

Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt drug activity in Atlanta?



Source: Law enforcement respondent

What they have to say...

- *Drug marketing innovations that have posed the greatest challenges for narcotics enforcement include more organized sales networks, relocations of sales settings within the community, and throwaway cell phones.*[L]

COMMUNITY INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS: HOW SUCCESSFUL HAVE THEY BEEN?

- Task forces: Like in many *Pulse Check* cities, task forces rate as the most successful law enforcement innovation for combating drug activity. The law enforcement source suggests even more communication between local law enforcement and regional and Federal task forces.
- Drug courts: Over the past 10 years, the number of drug courts has increased, and Atlanta now has county- and municipal-level drug courts.[N]

SEPTEMBER 11 FOLLOWUP

The law enforcement source reports a large decline in the supply of crack and powder cocaine since September 11, 2001. The methamphetamine supply, which has increased recently, may be substituting for the lack of cocaine. The non-methadone treatment source reports a general increase in mental health disorders and comorbidity among treatment clients.[N]