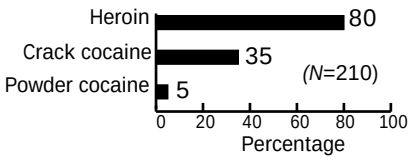
BALTIMORE PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 2,552,994
- Median age: . . . . . 36.6 years
- Race (alone):
  - White: 67.3%
  - Black: 27.4%
  - American Indian/ Alaska Native: 0.3%
  - Asian/Pacific Islander: 2.7%
  - Other race: 0.7%
  - Two or more races: . . . 1.5%
- Hispanic (of any race): 2.0%
- Unemployment rate: 3.3%
- Median household income: $49,938
- Families below poverty level with children <18 years: 10.3%

*Source: U.S. Census 2000**

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



Notes: These numbers may include client reports of two primary drugs of abuse. No clients report marijuana, methamphetamine, or ecstasy as a primary drug of abuse.[N]

Source: Non-methadone treatment respondent

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

Two of the *Pulse Check* respondents believe that Baltimore's drug problem is stable,[L,E] while the two treatment respondents report a worsening situation.[N,M] All four agree, however, that the city's overall drug problem is either somewhat[L,E] or very[N,M] serious. Some changes are reported since spring 2002:

- Abuse of OxyContin® (oxycodone hydrochloride controlled-release) appears to have decreased somewhat since the spring[E,N] The drug is no longer considered a new or emerging drug, but rather part of the drug culture.[E]
- OxyContin® is now most commonly diverted through prescription fraud, as opposed to pharmacy burglaries as was the case in past reporting periods.[L]
- The percentage of primary heroin users in treatment increased.[M]
- Methylenedioxymethamphetamine (MDMA or ecstasy) remains easily accessible to adolescents in school settings.[L,E]
- Ecstasy has penetrated the traditional drug market, especially suburban and rural youth.[L]
- Marijuana dealers have recently begun selling joints dipped in phencyclidine (PCP).[L]
- Juveniles are involved in distributing marijuana, often through "underground networks."[L]

Three of the four respondents indicate that heroin is the city's most widely abused drug, and all concur that crack cocaine is the second most widely abused drug in Baltimore. The methadone treatment source reports benzodiazepines as the drugs related to the most serious consequences—unlike nearly all other *Pulse Check* methadone sources, who consider heroin as such.

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

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

Second most widely abused drug:
Crack cocaine[L,E,N,M]

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

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

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

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

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

New or emerging problems:
Ecstasy is penetrating the traditional drug market.[L]
Diverted OxyContin® has grown from a new/emerging drug to a part of the traditional drug culture.[E]

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.

**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.*

HEROIN

Three sources consider heroin to be Baltimore's most widely abused drug,[E,N,M] and two associate the most serious drug-related consequences with the drug.[L,E]

- The percentage of primary heroin users in treatment increased, with 70 percent representing return clients within the methadone program.[M]
- Demand for heroin is increasing.[L]
- New street names for heroin appeared in Baltimore since the spring: (1) "dope"[N] and (2) "the bomb," which refers to heroin from Washington, DC, that has an estimated purity of 20 percent.[L]

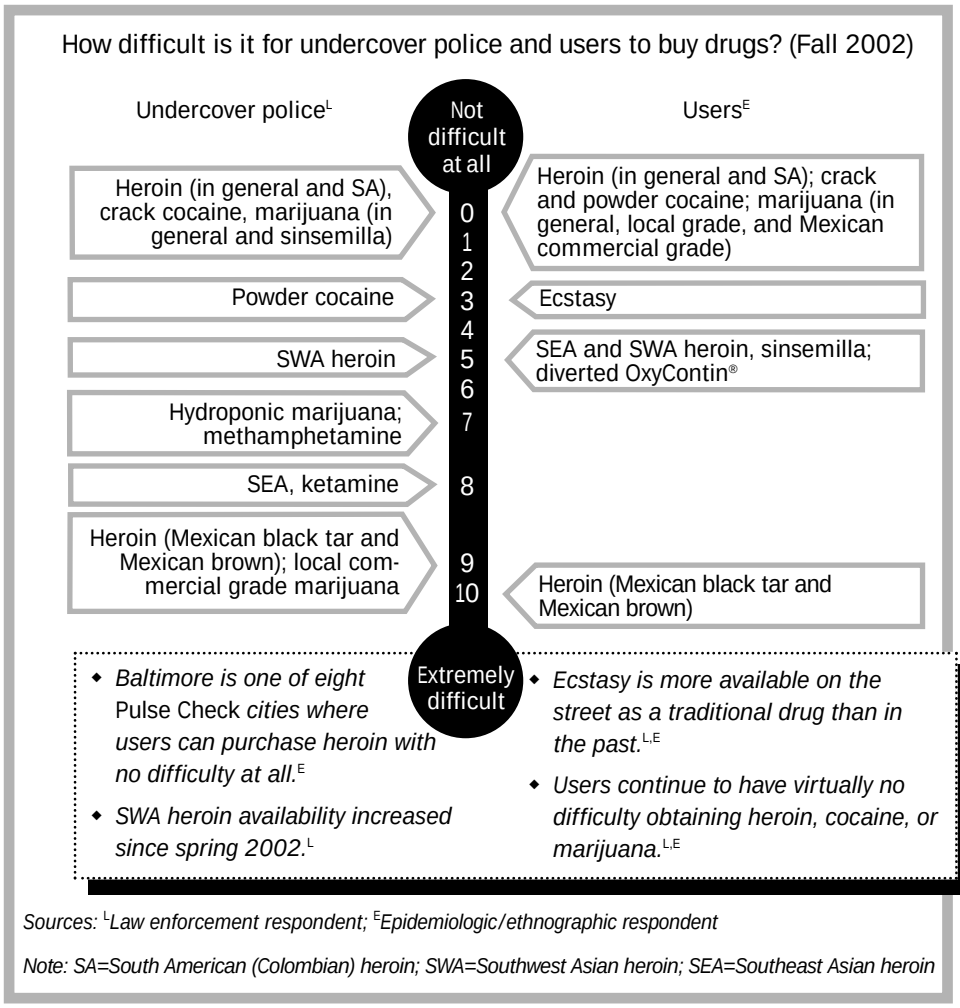
COCAINE

All four respondents consider crack cocaine to be Baltimore's second most widely abused drug, and three associate it with the second most serious drug-related consequences. The crack problem has, however, remained stable since spring 2002, and abuse of powder cocaine remains stable at very low levels.[N,M]

MARIJUANA

The marijuana problem in Baltimore appears stable, although use remains at high levels.[E,N]

- Marijuana is the primary drug of abuse among preadolescents and adolescents.[E]
- Marijuana dealers recently began selling joints dipped in PCP.[L]



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

Note: SA=South American (Colombian) heroin; SWA=Southwest Asian heroin; SEA=Southeast Asian heroin

METHAMPHETAMINE

Methamphetamine use remains stable at very low levels among treatment clients,[N,M] and is fairly difficult to purchase on the street.[L,E]

- The methamphetamine that does appear on the drug market generally comes from west of Baltimore.
- There is some evidence of a few small labs within the city.

MDMA (ECSTASY)

Ecstasy use remains stable at low levels,[N,M] but is increasingly available on the street.[L,E]

OTHER DRUGS

- Diverted OxyContin®: After a large increase in primary OxyContin® abusers in the non-methadone program last spring, the numbers have declined to nearly zero. This is partly attributable to the non-methadone clinic's move into a "heavy heroin neighborhood" during the reporting period. The ethnographic/epidemiologic respondent similarly notes a slight decrease in abusers of OxyContin®.
- Ketamine: While ketamine abuse is not pervasive in Baltimore, the drug is well known among youth.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment facility has the capacity to serve 160 clients; however, its current enrollment exceeds capacity at 210. Among these clients, the primary drug of abuse is heroin, with crack cocaine the distant second *(see bar chart on the first page of this chapter)*. This clinic relocated during the reporting period, accounting for some of the changes seen among treatment clients *(see the Other Drugs arrow on the previous page)*.
- The methadone treatment facility can serve up to 620 clients, with a current enrollment of 597. Seventy percent of the program's treatment population are return clients for primary heroin abuse.[M]
- While treatment is somewhat more available through both public and private clinics in Baltimore, methadone programs continue to have waiting lists several months long.[E,M]

Consequences of drug use

- The number of clients with hepatitis C increased significantly in the non-methadone program, largely attributable to the clinic's new location: a significant number of clients come to treatment directly from jail, where hepatitis C prevalence is great.[N] In the methadone program, hepatitis C diagnoses remain stable at high levels.[M]
- An increase in drug-related automobile accidents is noted among methadone treatment clients.[M]

Co-occurring disorders

- A lack of trained staff to treat comorbid clients increased as a major barrier to treatment within the methadone program, due to insufficient funding for staff and the increased severity of patient problems.[M]
- The rate of clients with dual diagnoses in the methadone program remains high, at 80 percent. Mood disorders account for the majority of the mental health issues.[M]
- Comorbidity (psychosis, mood disorders, post-traumatic stress disorder [PTSD], and physical and sexual abuse) increased among clients in the non-methadone treatment program. This is due to more effective identification of dual diagnoses by new staff trained to treat comorbid disorders.[N]

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.

- *The education level of heroin users declined, with more clients in the methadone program achieving less than a GED (general equivalency diploma).*[M]
- *While the majority of heroin users in treatment are male (65 percent), new treatment clients are more evenly distributed between males and females.*[M]
- *The primary referral source for heroin users in the methadone program is now the criminal justice system. Previously, most clients were self-referred or came from the health care system. This change is attributable to a recent anticrime push by the Baltimore Health Department that involves many heroin users.*[M] *Similar shifts are reported in other* Pulse Check *cities.*

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	35	37	40
Gender	Male	70% male	65% male
Race/ethnicity	Black	Black	White and Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice
Level of education completed	N/A	Did not complete school	Did not complete school
Employment at intake	N/A	Unemployed	Unemployed

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

- *While the typical heroin user takes the drug alone, most new treatment clients use heroin in groups and with friends.*[N,M] *Also, these new clients tend to snort the drug, while the overall treatment population snorts and injects heroin equally.*[M]
- *Common adulterants to heroin include baking soda, quinine, rat poison, Ajax® cleanser, arsenic, and benzodiazepines.*[N]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Snorting	Snorting and injecting
Other drugs taken	Powder cocaine	Powder cocaine	Crack cocaine
Publicly or privately?	Both	Privately	Privately
Alone or in groups?	In groups	Alone	Alone

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

- *An emerging practice of injecting crack cocaine is noted.*[E]
- *Crack cocaine users often take the drug along with heroin.*[N]
- *Common adulterants to both forms of cocaine include baking soda, quinine, rat poison, Ajax® cleanser, arsenic, and benzodiazepines.*[N]

Who's most likely to use cocaine?

	Crack cocaine			Powder cocaine
Characteristic	E	N	M	N
Age group (years)	18–30	>30	>30	>30
Mean age (years)	NR	35	35	35
Gender	Male	60% female	Female	60% female
Race/ethnicity	Black	Black	Black	Black
Socioeconomic status	Low	Low	Low	Low
Residence	Central city	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice	Criminal justice
Level of education completed	N/A	Did not complete school	Did not complete school	Did not complete school
Employment at intake	N/A	Unemployed	Unemployed	Unemployed

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

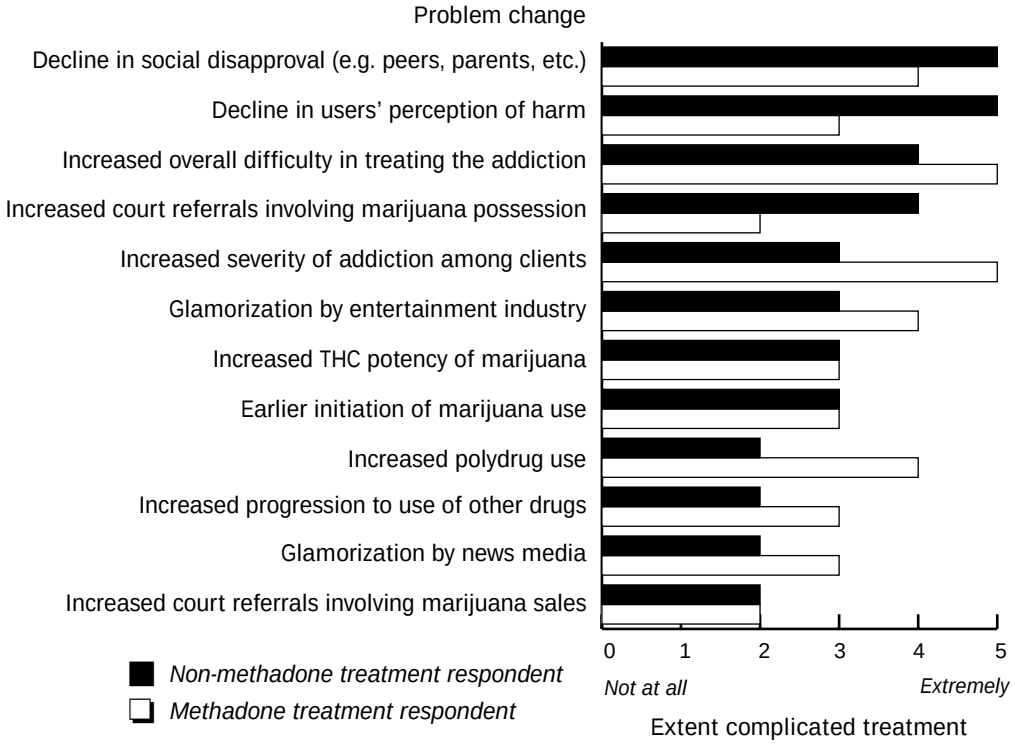
- *Primary marijuana users are younger than users of other drugs: they are typically adolescents and young adults. Marijuana is the most widely abused drug for these age groups.*[E,N]
- *Primary marijuana users who are referred to treatment by the criminal justice system are generally arrested for possession of marijuana as opposed to selling the drug.*[N]
- *As in most* Pulse Check *cities, marijuana use occurs across age groups.*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–17	18–30	>30
Gender	Male	95% male	70% male
Race/ethnicity	Black	Black	Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice
Level of education completed	N/A	Did not complete school	Junior High
Employment at intake	N/A	Unemployed	Unemployed

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

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



WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

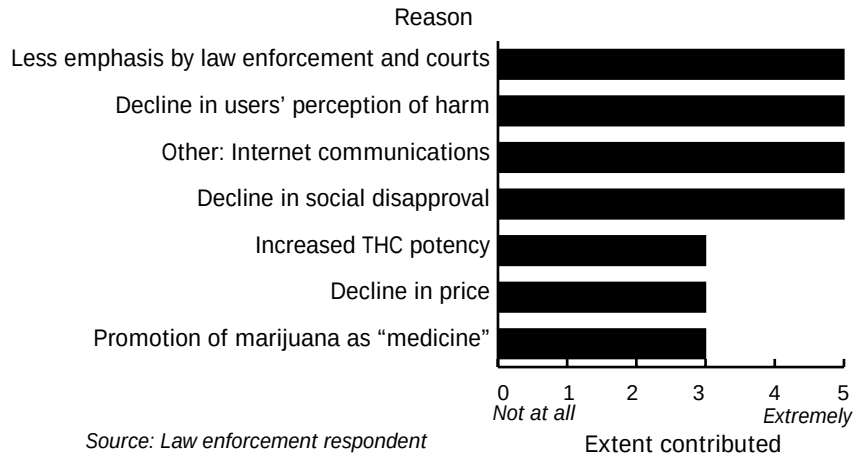
Respondents associate marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:

- Drug-related arrests[N,M]
- Short-term memory loss[N,M]
- Deteriorating family and social relationships[N]
- Poor academic performance[M]
- Poor workplace performance[M]
- Unemployment rates[N]

What they have to say...

- *Perception of harm/social disapproval: Two factors that particularly complicate treatment of marijuana-using clients are the declines in users' perception of harm[N] and in social disapproval of marijuana use—perceptions shared by treatment sources in many* Pulse Check *cities.*[N,M]
- *Treatment difficulty: Because marijuana abusers in treatment now are younger than the rest of the treatment population, they have few life experiences without drug use, making it more difficult to treat their addiction.*[N]
- *Polydrug use: Polydrug use among marijuana users is far more common than it was a decade ago, increasing the severity of their addiction and making it more difficult to treat them.*[M]
- *Entertainment industry: Glamorization of marijuana use is cited as a major contributor to the increased difficulty in treating marijuana addiction. This includes primarily the music industry (including music videos) and movies.*[N,M]

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



Source: Law enforcement respondent

WHO'S MOST LIKELY TO USE ECSTASY?

- Ecstasy users in Baltimore are primarily young adults using privately in groups or among friends;[E,M] males and females are equally likely to use the drug.[E]
- Blacks residing in the central city are growing as an ecstasy-using population,[E,M] shifting from primarily White users living in more suburban and rural areas.[E]
- Primary ecstasy users are generally more educated than primary users of other drugs.[M]

What they have to say...

- *Law enforcement/courts: Compared with many other* Pulse Check *cities, the Baltimore law enforcement and court system seems to place less emphasis on marijuana (according to average ratings by* Pulse Check *law enforcement sources).*
- *Perception of harm: Widespread availability and use of marijuana among youth has been substantially affected by a decline in users' perception of harm. Further, not only has there been a notable decline in social disapproval of marijuana use, but there is now significant peer pressure to smoke marijuana.*[L]
- *Internet: Communications over the Internet make information about marijuana easily accessible and has increased pressure to use the drug.*[L]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, cocaine, and marijuana are sold throughout the city in all of these settings:[L,E]

- Streets/open-air markets
- Crack houses/shooting galleries
- Private residences
- Public housing developments
- College campuses
- Nightclubs/bars
- Shopping malls
- Playgrounds/parks
- Private parties
- Raves
- Concerts
- Hotels/motels
- Around drug treatment clinics
- Inside cars

Cocaine is also used in these settings, with the exception of college campuses, shopping malls, raves, and around drug treatment clinics. While heroin is sold in these varied settings, it is generally used in the streets, in crack houses/shooting galleries, private residences, public housing developments, playgrounds/parks, hotels/motels, and inside cars.

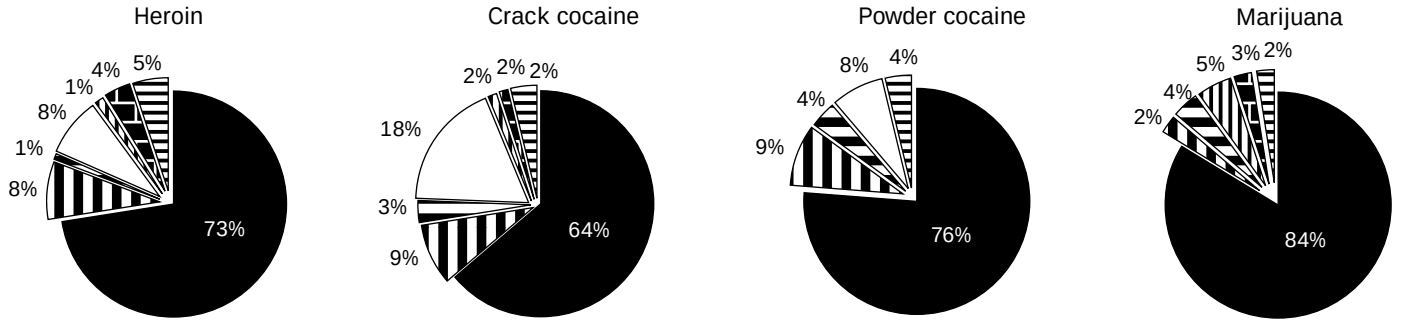
In addition to all the locations listed above, marijuana is also sold in school settings.[L] Users smoke the drug in all of the sale settings except for schools, shopping malls, and around drug treatment clinics.[E]

Ecstasy sales have moved into many of these traditional drug markets, including the streets, private residences, schools and colleges, nightclubs/bars, shopping malls, playgrounds/parks, private parties, at raves and concerts, and inside cars. The drug is also used in all of these settings, except for playgrounds/parks and concerts.[L,E]

HOW DO DRUGS GET FROM SELLER TO BUYER?

- Transactions involving heroin and cocaine generally take place in the central city,[E] although cocaine sales also occur in large numbers in the suburbs.[L]
- Heroin and cocaine users often have one dealer, who will get whatever they request through either open-air markets or telephone communications.[E] Users often go to a known market area to find such a dealer.[L] The dealer sometimes takes the money for the drugs and then directs the user where to pick them up.[L]
- Some dealers distribute free drugs to "testers" early in the morning, and then count on word-of-mouth to bring them more buyers throughout the day based on the quality or purity of the drug.[E]
- Marijuana and ecstasy sales take place in all areas of Baltimore. Dealers often sell these two drugs only.[L,E]
- While ecstasy users formerly needed to know a dealer personally, the drug is becoming more common on the street.[L]
- Diverted OxyContin® is typically acquired through prescription fraud, with one person giving addicts fraudulent prescriptions to fill; the user then returns the filled prescription to the dealer, who gives some back to the user and sells the rest.[L]

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



What they have to say...

- *As in all* Pulse Check *cities, cash remains the primary currency for drug transactions in Baltimore.*[L,E,N,M]
- *While the exchange of sex for drugs is a common practice for drugs like heroin and cocaine, it is virtually unheard of among marijuana users.*[L,E,N,M]
- *Receiving marijuana as payment for providing drug buying services is more common for marijuana transactions than for those involving other drugs.*[M]

- Cash
- Shoplifted merchandise
- Property/Merchandise
- Sex
- Drug buying services
- Lookout services
- Other: Includes items accounting for less than 3 percent of transactions for all four drugs, such as other drugs, transporting the drugs, food stamps, and injecting services.

Note: The epidemiologic/ethnographic source provided information about heroin only.

Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents

WHO'S SELLING HEROIN?

- Heroin sellers in Baltimore range from adolescents and young adults operating independently[E] to adults working within organized structures.[L]
- An increasing level of violence is associated with heroin dealers, due to gangs seeking new "territories" within the city.[E]
- Heroin dealers sometimes sell heroin and powder cocaine in one bag for speedballing.[E]

WHO'S SELLING COCAINE?

- Dealers of both crack and powder cocaine work within structured organizations and are often involved in prostitution, gang-related activity, and violent criminal acts.[L,E]
- Crack dealers are younger than powder cocaine dealers.[L,E]
- Powder cocaine dealers often pack the drug in pills and lace it with heroin.[E]

WHO'S SELLING MARIJUANA?

- Persons of all ages, from preadolescents to adults, sell marijuana.[L,E]
- Marijuana dealers are likely to use the drug as well,[L,E] and are often involved in both violent and nonviolent criminal acts.[L]

WHO'S SELLING METHAMPHETAMINE?

- Sales of methamphetamine are very low throughout Baltimore, but there are some indications of lab activity in the city.[L]
- Those who do sell the drug are young adults working independently.[L]

WHO'S SELLING ECSTASY?

- Adolescents continue to represent the vast majority of ecstasy dealers,[E] although young adults also commonly deal the drug.[L]
- Most ecstasy dealers work independently.[L]

How much does heroin cost?

Unit	Price
Vial	$5–$10[E]
Bag	$10[L]
Capsule	$10[L]

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

All reported prices are stable between spring and fall 2002.

How much does cocaine cost?

Form	Unit	Price
Crack	Rock	$5–$10[L,E]
Powder	Vial/"baggie"	$5–$10[E]
	1 g	$90–$100[L]
	3–5 g	$270–$500[L]

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

- *All reported prices are stable between spring and fall 2002.*
- *Dealers will break off a particular size of rock depending on how much money the user can pay.*[E]

How much does marijuana cost?

Unit	Price
Joint	$1–$3
Blunt	$10–$12
Ounce	$100
Pound of sinsemilla	$3,700–$4,700

Source: Law enforcement respondent

All reported prices are stable between spring and fall 2002.

Who's selling other drugs, and how much do they cost?

Drug	Unit	Price
Diverted OxyContin®	1 mg	$1[L]
	1 pill	$30[E]
Ecstasy	1 pill	$18–$20[L]

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

- *All prices are stable between spring and fall 2002.*
- *Unlike many other cities such as Philadelphia and Detroit, diverted OxyContin® dealers in Baltimore typically use the drug themselves, and are also involved in both prostitution and property crimes.*[L,E]
- *Young adults working independently are the primary dealers of ketamine, which they obtain through burglaries of veterinary clinics.*[L]

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Diverted OxyContin®	Ketamine
Gang-related activity	✓	✓	✓			
Violent criminal acts	✓	✓	✓	✓		
Nonviolent criminal acts	✓	✓	✓	✓	✓	✓
Prostitution	✓	✓	✓		✓	

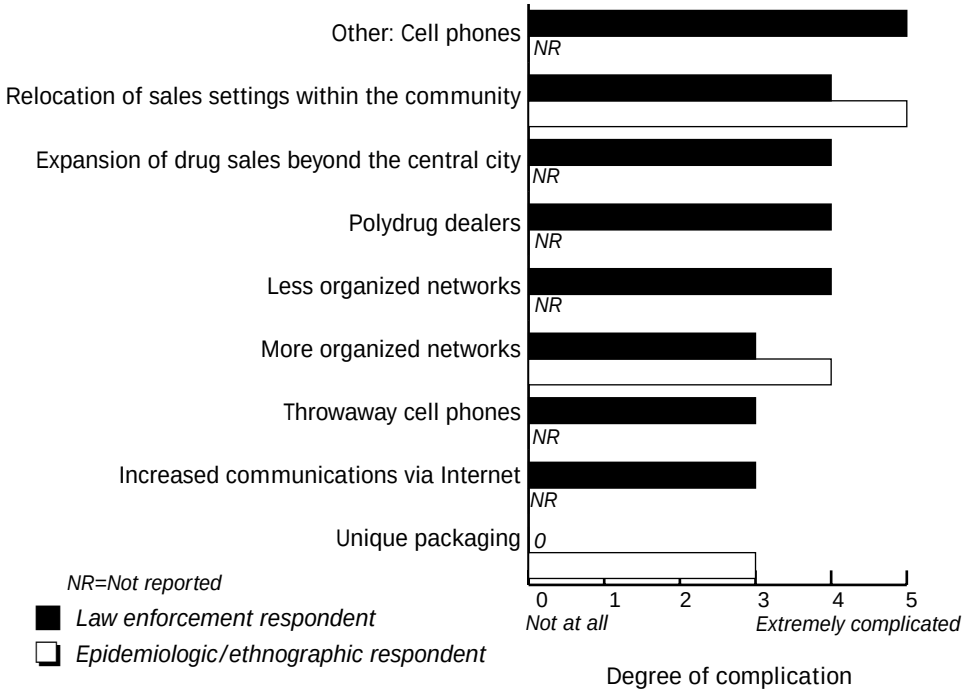
Sources: Law enforcement and epidemiologic/ethnographic respondents

THE MARKET PERSPECTIVE: A 10–YEAR VIEW

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

What they have to say...

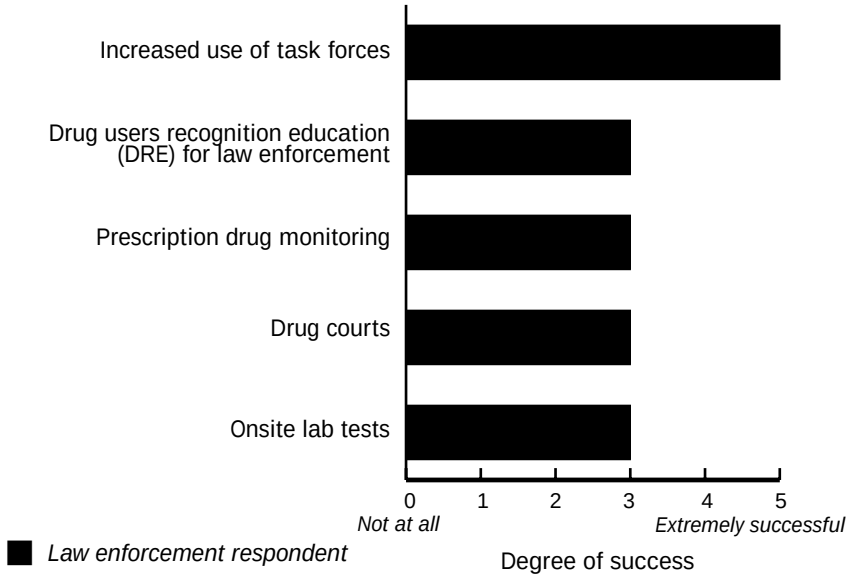
- *A Baltimore source articulates a belief shared by the vast majority of sources in other* Pulse Check *cities: The proliferation of cellular phones over the past decade has caused more problems than anything else in law enforcement efforts to disrupt drug activity. It has changed the ways that law enforcement can intercept transactions and provides sellers with a degree of protection.*[L]
- *The relocation of sales settings within the community represents a substantial complication of efforts to detect or disrupt drug activity in Baltimore.*[E]



What they have to say...

- *Like other* Pulse Check *cities, Baltimore has used task forces effectively. Regional task forces, in particular, can readjust their focus as needed.*[L]
- *Drug courts have been largely successful, but resources are currently limited. Law enforcement is seeking to expand the drug courts into several jurisdictions.*[L]
- *While onsite lab tests located on police premises have been beneficial, law enforcement points to a need for availability of reliable portable kits to all officers working in the field.*[L]
- *Law enforcement stresses that the key to reducing drug supply and sales is to somehow reduce dealers' profit margin.*[L]

Community innovations and tools over the past 10 years:
How successful have they been?



SEPTEMBER 11 FOLLOWUP

Three of the four *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no continuing effects on the drug abuse problem in Baltimore. The law enforcement respondent, however, notes two continuing effects also noted by *Pulse Check* sources in other cities. First, the switch in law enforcement focus to antiterrorist efforts has limited resources for fighting the city's drug problem. Second, while increased scrutiny at airports has curtailed drug trafficking in that venue, suppliers have simply increased their use of other means of transportation.