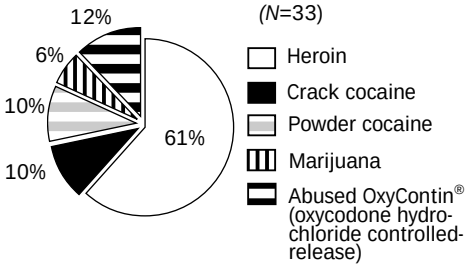
BOSTON PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 3,406,829
- Median age: . . . . . 36.3 years
- Race (alone):
  - White: 82.5%
  - Black: 7.0%
  - American Indian/ Alaska Native: 0.2%
  - Asian/Pacific Islander: 4.9%
  - Other race: 3.0%
  - Two or more races: 2.4%
- Hispanic (of any race): . . . 5.9%
- Unemployment rate: 2.9%
- Median household income: $55,183
- Families below poverty level with children <18 years: 8.6%

*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; responses for primary ecstasy and methamphetamine use were zero.

Heroin remains the most common primary drug of abuse among non-methadone treatment admissions, and OxyContin® abuse increased slightly between spring and fall 2002.[N]

**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.*

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

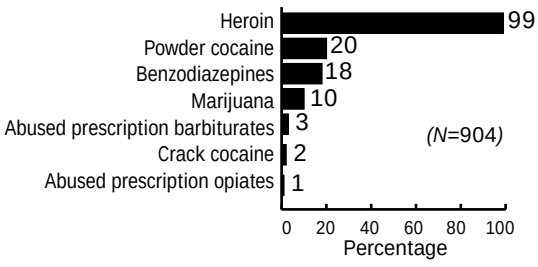
Three of the *Pulse Check* sources believe that the area's overall drug abuse problem has remained stable at high levels,[L,E,N] while the methadone treatment respondent believes it has worsened. Sources report several specific developments:

- Three drug abuse-related health consequences have declined since spring, including tuberculosis (due to improved testing and treatment),[N] suicide (due to increased crisis intervention among younger clients),[N] and high-risk pregnancies.[M]
- Diverted OxyContin® availability declined, it is more difficult to purchase, and pharmacy robberies continue to decline.[L,E,N] These declines are most likely due to media coverage of its abuse and increased law enforcement attention. However, Boston is now witnessing the "substitution effect": because the drug is no longer widely available, OxyContin® abusers are switching to other forms of oxycodone (Percocet®), clonazepam (Klonopin®), fentanyl, or heroin.[E] One respondent explains that OxyContin® abusers are switching to "whatever drug is most available."[N]
- Among methadone treatment admissions, marijuana use declined slightly.[M]
- Gamma hydroxybutyrate (GHB) has become more difficult to purchase.[E]
- Methylenedioxymethamphetamine (MDMA or ecstasy) use increased slightly, but at a slower rate than it has in the past.[E]
- Cocaine (crack and powder) use increased. This resurgence may have occurred because adolescents and young adults who began using heroin several years ago have switched to cocaine use.[E]

Several marketing methods for heroin and cocaine sales have changed:

- Many drug sales have moved indoors to inconspicuous or anonymous places, such as rooftops, hallways, and restaurants.[E]
- Sales are increasingly "underground" and are facilitated by beepers and cell phones.[L]
- Heroin and powder cocaine sales continued to become more decentralized, and the numbers of independent dealers increased.[L,E]
- Polydrug sellers (typically of heroin and crack and powder cocaine) continued to increase.[E]

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



Among methadone treatment admissions, marijuana use declined slightly and benzodiazepine abuse declined dramatically since spring 2002. Among methadone clients new to treatment, powder cocaine use increased slightly.

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

Source: Methadone treatment respondent

THE BIG PICTURE (continued)

The most widely abused drugs in Boston are marijuana (as in 21 other *Pulse Check* cities) and heroin (as in only 6 other *Pulse Check* cities). The drugs related to the most serious consequences include heroin, powder cocaine, and crack. OxyContin®[L,N] and ecstasy[L] abuse and activity continue to emerge.

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

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

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

Powder cocaine replaced marijuana as the second most widely abused drug.[N]

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

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

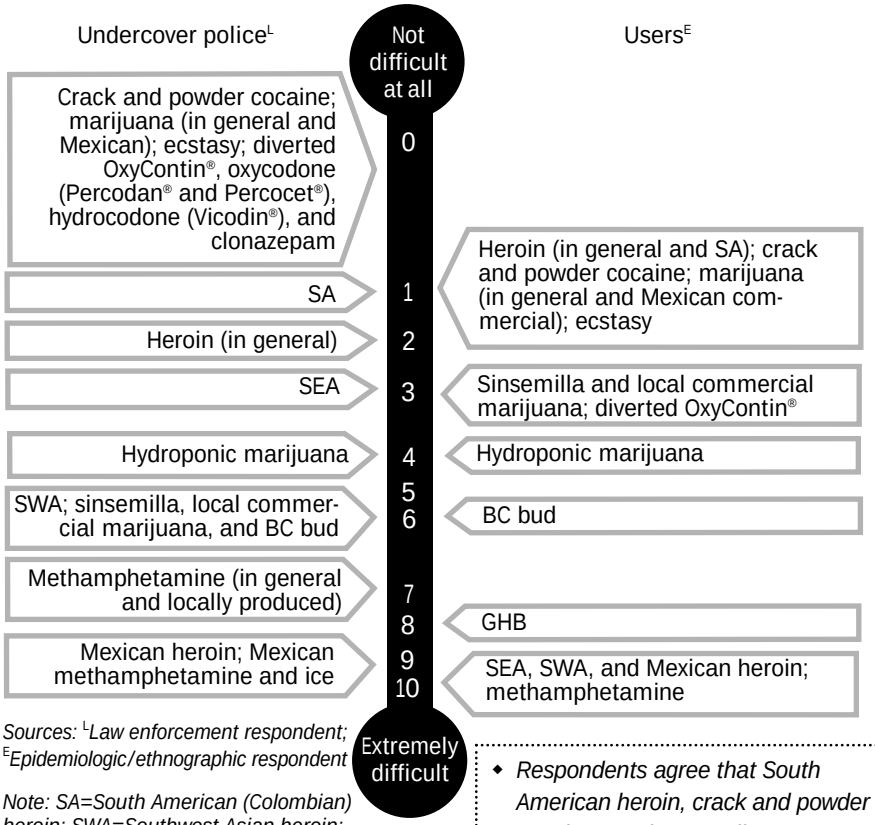
Drug related to the second most serious consequences:
- Heroin[L,E]
- Crack cocaine[N]
- Powder cocaine[M]

Crack replaced powder cocaine as the drug related to the second most serious consequences.[N]

New or emerging problems:
- OxyContin® abuse continues to increase.[L,N]
- Ecstasy use continues to increase.[L]

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)



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

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

- *Respondents agree that South American heroin, crack and powder cocaine, Mexican marijuana, ecstasy, and diverted OxyContin® are relatively easy to purchase in Boston.*[L,E]
- *As in three other* Pulse Check *cities (Cleveland, Miami, and Washington, DC), users found it more difficult to purchase diverted OxyContin® in fall 2002. Its high price caused demand to drop, which then caused supply to drop. Sales of other diverted oxycodone products, such as Percocet®, have taken the place of OxyContin® sales.*[E]
- *Since spring 2002, users have found GHB harder to purchase.*[E]

HEROIN

- Heroin use remained stable at relatively high levels, with increases among young adult users.[E,N]
- OxyContin® and other prescription opiate abusers are increasingly switching to heroin use.[E]

COCAINE

- Cocaine (crack and powder) use increased between spring and fall 2002. This resurgence may have occurred because adolescents and young adults who began using heroin several years ago have switched to cocaine use.[E]
- Among methadone admissions new to treatment, powder cocaine use increased between spring and fall 2002—a consistent finding across Massachusetts.[M]

MARIJUANA

Marijuana remains one of the most widely used and available drugs in Boston; however, among methadone treatment admissions, marijuana use declined slightly between spring and fall 2002. Moreover, this group of users aged slightly, and males increased dramatically.[M]

METHAMPHETAMINE

Methamphetamine use remains low, and treatment admissions who use methamphetamine are negligible.

MDMA (ECSTASY)

Ecstasy use increased slightly since spring 2002, but at a slower rate than it has in the past.[E] Adolescent use of the drug is increasing at a faster rate than young adult use.

DIVERTED OXYCONTIN®

- While diverted OxyContin® remains somewhat available, abusers found it more difficult to purchase in fall 2002. Its high price caused demand to drop, which then caused supply to drop.[E]
- Because of its high price and decreased availability, abusers have increasingly switched from OxyContin® abuse to other prescription opiate or heroin abuse.[L,E]
- Non-methadone admissions to treatment for OxyContin® ("OCs") abuse have increased slightly, but among the general population, OxyContin® abuse has leveled off.[N]

OTHER DRUGS

- Benzodiazepines: Although benzodiazepine abuse among methadone treatment clients remains relatively high, the proportion has declined dramatically between spring and fall 2002.[M]
- GHB: GHB became harder to purchase between spring and fall 2002.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone respondent is with an inpatient facility that treats adult males and is at 100 percent capacity (33 of 33 slots). Heroin remains the most common primary drug of abuse *(see pie chart on the first page of this chapter)*, and treatment percentages are stable, with the exception of an increase in OxyContin® abuse.[N]
- The methadone treatment respondent is with a facility that operates at about 90 percent capacity (904 of 1,000 slots).[M] Twenty percent of its heroin clients also use powder cocaine, and 18 percent abuse benzodiazepines *(see bar graph on the first page of this chapter)*.
- Methadone maintenance treatment is available throughout the Boston area, but there are waiting lists: 1–2 months for public treatment and 3–4 months for private treatment. Capacity and treatment availability remained stable between spring and fall 2002.[E]

Consequences of drug use

- Hepatitis C and drug overdoses remain the most common drug abuse-related health consequences among non-methadone treatment clients. Hepatitis C detection has increased, most likely due to new and improved testing and increased awareness of the problem. Drug overdoses are most often related to heroin and OxyContin® abuse, typically among young, inexperienced drug users.
- Several drug abuse-related health consequences have declined since spring 2002, including tuberculosis (due to improved testing and treatment) and suicide (due to increased crisis intervention among younger clients).[N]
- Among methadone treatment clients, the most common drug abuse-related health consequence is hepatitis C, which continues to increase, as do related medical problems such as liver cancer. Because the average age of clients is increasing, age-related medical problems have intensified. High-risk pregnancies declined slightly between spring and fall 2002.[M]

Barriers to treatment

- Limited slot capacity remains the number-one barrier to non-methadone treatment, and it has increased as a problem since spring 2002.[N] The lack of residential recovery homes for clients has also increased as a problem.

- Although lack of transportation, money for transportation, and insurance coverage has remained relatively stable as a problem, the methadone treatment respondent believes that in 2003 it may increase due to upcoming cuts in insurance coverage for drug treatment.[M]

Comorbidity and recidivism

- The most common co-occurring disorders among methadone treatment clients remain antisocial or conduct disorders and mood disorders, all of which continue to increase.[M] Psychosis, although occurring at lower levels than conduct and mood disorders, also continues to increase.
- Nearly all primary heroin admissions in the non-methadone treatment program have received treatment (for heroin or any drug) previously, and about 25 percent of methadone clients have received treatment previously.[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 heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	37	30	42.2
Gender	Male	100% male*	58% male
Race/ethnicity	White	White	White
Socioeconomic status	Low	Middle	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Alcohol/drug abuse care provider	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Unemployed

**The non-methadone program serves only males.*

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

- *Sources agree that most heroin users are White males who live in the central city.[E,N,M] Treatment sources agree that most heroin admissions are high school graduates and are currently unemployed.[N,M]*
- *The emerging group of heroin users are Whites who have recently switched from OxyContin® abuse to injecting heroin.[E]*
- *New heroin users are much younger than the general heroin-using population (mean age of 20 years versus 37 years).[E]*
- *Between spring and fall 2002, heroin treatment admissions are younger, and more are referred by the criminal justice system.[N]*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Cocaine (speedball); benzodiazepines, prescription opiates, and marijuana	Marijuana (in combination)	Powder cocaine (speedball), crack (sequentially), benzodiazepines ("BZs"), marijuana (in combination)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups	Alone	Alone

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

- *Sources agree that injecting is the most common route of heroin administration in Boston.[E,N,M]*
- *Among young heroin admissions, snorting is the most common route of administration, but these users often switch to injecting as they age.[N]*
- *Speedball injection is common, but the use of crack in speedballs has leveled since spring 2002.[E]*

Who's most likely to use cocaine?

Characteristic	Crack cocaine			Powder cocaine		
	E	N	M	E	N	M
Age group (years)	>18	18–30	>30	>30	>30	>30
Mean age (years)	30	NR	30.1	35	NR	40.2
Gender	60% male	100% male*	55% male	70% male	100% male*	55% male
Race/ethnicity	Black	White	White	White	White	White
Socioeconomic status	Low	Low	Low	Middle	Low, middle	Low
Residence	Central city	Central city	Central city	Suburbs	Central city, suburbs	Central city
Referral source	N/A	Criminal justice, alcohol/drug abuse care provider	Individual	N/A	Alcohol/drug abuse care provider	Individual
Level of education completed	N/A	2-year college	High school	N/A	2-year college	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Unemployed	Unemployed

**The non-methadone program serves only males.*

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

- *Cocaine (crack and powder) use increased between spring and fall 2002. This resurgence may have occurred because adolescents and young adults who began using heroin several years ago have switched to cocaine use.*[E]
- *Among methadone admissions new to treatment, powder cocaine use increased between spring and fall 2002—a consistent finding across Massachusetts.*[M]
- *Among methadone treatment admissions, crack and powder cocaine users aged slightly, and females increased (from 40 to 45 percent) between spring and fall 2002.*[M]
- *Two respondents agree that crack users are younger, more likely to live in the central city, and of lower socioeconomic status than powder cocaine users.*[E,N]
- *Other drugs commonly used sequentially with crack or powder cocaine include heroin,*[E,M] *marijuana,*[E] *benzodiazepines,*[E,N] *and prescription opiates.*[E]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	18–30	18–30	>30
Mean age (years)	25	NR	40
Gender	60% male	100% male*	72% male
Race/ethnicity	White	White	White
Socioeconomic status	Middle	Low, middle	Low
Residence	Suburbs	Central city, suburbs	Central city
Referral source	N/A	Criminal justice (for marijuana sales), alcohol/drug abuse care provider	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Unemployed

**The non-methadone program serves only males.*

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

- *Most marijuana users in Boston are young adult Whites who live in the central city and suburbs.*[E,N]
- *New marijuana users are younger than the general marijuana-using population (mean age of 16 versus 25 years). Marijuana use is on the rise among this new group.*[E]
- *Among methadone treatment admissions, marijuana use declined slightly between spring and fall 2002. Moreover, this group of users aged slightly, and males increased dramatically.*[M]

How do users take marijuana?

Characteristic	E	N	M
Primary delivery vehicle	Joints	Joints	Joints
Other drugs taken	Powder cocaine, OxyContin®, benzodiazepines, ecstasy, lysergic acid diethylamide (LSD)	Phencyclidine (PCP) (in combination)	Heroin (sequentially)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups	In groups	In groups

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

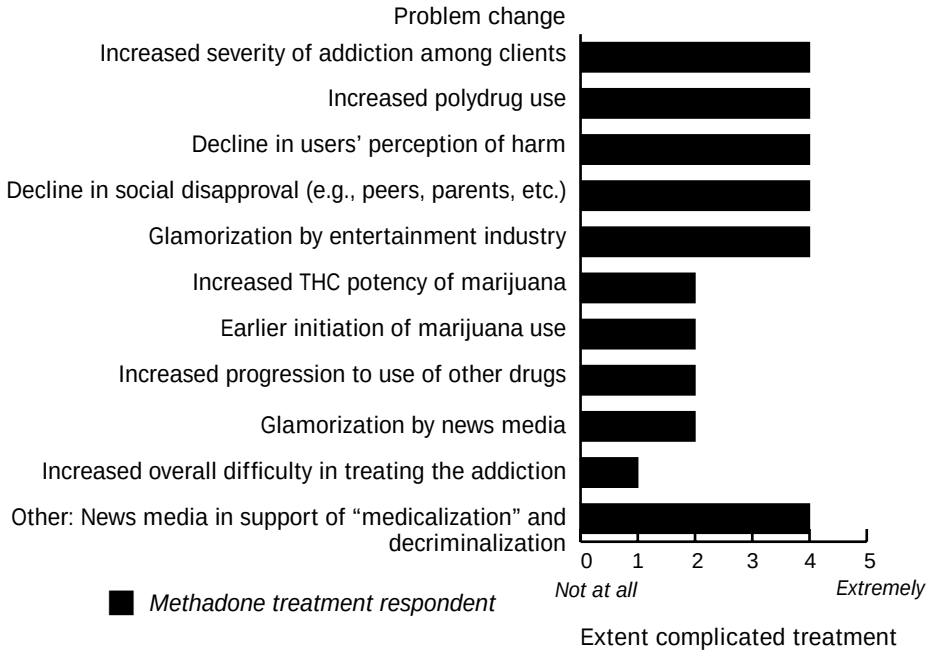
- *Sources agree that joints are the most common route of marijuana administration in Boston.*[E,N,M]
- *New, adolescent marijuana users are switching from joints to blunts and bongs. Typically Whites use bongs, and Blacks use blunts.*[E]
- *Sources agree that other drugs are commonly used with marijuana. The non-methadone treatment respondent states: "By the time marijuana users are referred to treatment, they tend to use many other drugs."*

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[E]
- Automobile accidents[E,N]
- Short-term memory loss[N,M]
- Deteriorating family or social relationships[E]
- Poor academic performance[M]
- School absenteeism or truancy[E,M]
- Poor workplace performance[M]
- Lack of motivation[M]

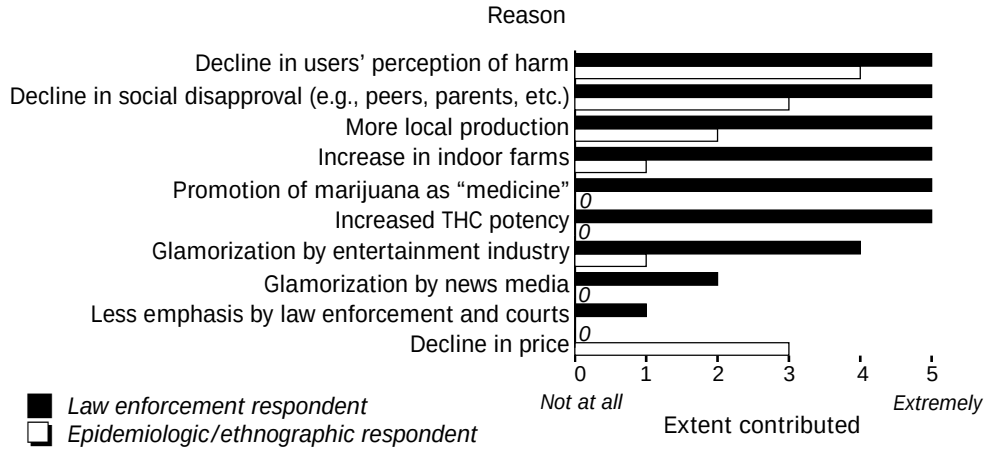
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

The methadone treatment source cites several changes as complicating treatment dramatically, including increased severity of addiction among clients, increased polydrug use, decline in users' perception of harm, decline in social disapproval, glamorization by the entertainment industry, and the news media's support of "medicalization" and decriminalization of the drug.[M]

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



What they have to say...
As in nearly all Pulse Check *cities, respondents in Boston agree that declines in users' perception of harm and in social disapproval of marijuana have contributed to widespread use of the drug.*

Who's most likely to use ecstasy?

Characteristic	E
Age group (years)	18–30
Mean age (years)	25
Gender	Split evenly
Race/ethnicity	White
Socioeconomic status	Middle
Residence	Suburbs

Source: [E]Epidemiologic/ethnographic respondent

- *Ecstasy use increased slightly between spring and fall 2002, but at a slower rate than it has in the past.[E] Adolescent use of the drug is increasing at a faster rate than young adult use.*
- *Use among private high school students continues to increase.[E]*
- *Use among the treatment population is very low.[N,M]*
- *Most ecstasy is taken orally, but anecdotal reports of crushing the tablets, adding water, and heating the solution for injection increased. Other drugs, such as heroin and ketamine, are sometimes added to the injectable solution.[E]*
- *Ecstasy is commonly used with marijuana, LSD, GHB, heroin, and ketamine.[E]*

Who's most likely to abuse OxyContin®?

Characteristic	E	N	M
Age group (years)	>18	18–30	>30
Mean age (years)	35	16–30	41
Gender	70% male	100% male*	58% female
Race/ethnicity	White	White	White
Socioeconomic status	Low	Low, middle	Low
Residence	Central city, rural	Central city	Central city

**The non-methadone program serves only males.*

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

- *Although non-methadone admissions to treatment for OxyContin® ("OCs") abuse increased slightly, OxyContin® abuse has leveled off in the general population.[N]*
- *As with non-methadone treatment admissions for heroin, OxyContin® abusers are younger.[N] The ethnographic source states that most emerging OxyContin® abusers are the younger siblings of OxyContin® abusers.*
- *Diverted OxyContin® availability declined, most likely to due to media coverage of its abuse. However, Boston is now witnessing the "substitution effect": because the drug is no longer widely available, OxyContin® abusers are switching to other forms of oxycodone, clonazepam, fentanyl, or heroin.[E] The non-methadone treatment respondent explains that OxyContin® abusers are switching to "whatever drug is most available."*
- *Oral administration is the most common route of OxyContin® administration, followed by snorting and injecting.[E] The methadone treatment respondent reports the common practices of snorting crushed tablets and injecting the drug by crushing tablets, shaking the powder in cold water, and cooking the solution (a process known as "cold shake").*

WHO'S MOST LIKELY TO USE OTHER DRUGS?

- Methamphetamine: Use and treatment admissions are low in Boston, with the exception of sporadic reports of methamphetamine use among gay couples.[E]
- Benzodiazepines (Alprazolam [Xanax®] and clonazepam [Klonopin]®): Nearly 20 percent of methadone treatment clients also abuse benzodiazepines, but that proportion declined dramatically between spring and fall 2002. Benzodiazepine use among females declined, possibly because females are more compliant than males with a new policy of the treatment program: clients who use benzodiazepines without a prescription are eventually discharged.
- GHB: Use is relatively low, but reported as common among strippers.[E]
- Promethazine (Phenergan®): Methadone clients abuse this phenthiazine, known as "finnegan," to potentiate their methadone.[E]
- Barbiturates: Methadone clients abuse barbiturates, such as phenobarbital and migraine medications, by combining them with opiates. About 3 percent of methadone clients (a stable percentage between spring and fall 2002) abuse them as secondary or tertiary drugs.[M]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS SOLD?

All drugs available in Boston—including heroin, crack, powder cocaine, marijuana, methamphetamine (when available), diverted OxyContin®, ecstasy, and GHB—are sold in private residences, at private parties, or inside cars.[L] All drugs available, except for club drugs, are sold on the streets and around public housing developments.[L,E] In addition to the settings listed above, heroin, crack, powder cocaine, and marijuana are also sold in crack houses and shooting galleries, playgrounds and parks, and around supermarkets.[L]

Drug sales in high schools and on college campuses are common for powder and crack cocaine, marijuana, ecstasy, and diverted OxyContin®. Drug sales in nightclubs and bars, raves, and concerts are common for powder and crack cocaine, marijuana, methamphetamine, ecstasy, diverted OxyContin®, and GHB. Powder cocaine, marijuana, and ecstasy are sometimes sold via the Internet.[L]

The epidemiologic respondent claims that many drug sales have moved indoors to inconspicuous or anonymous places, such as rooftops, hallways, and restaurants.

HOW DO DRUGS GET FROM SELLER TO BUYER?

According to the law enforcement source:

Heroin, powder and crack cocaine, marijuana, and diverted OxyContin® are sold in a similar manner: a dealer has a small customer or clientele list, a buyer on the list contacts a dealer via beeper or cell phone, and the dealer delivers the drug to the buyer's residence. The small size of the clientele list protects dealers from law enforcement. These sales are increasingly "underground" and are facilitated by beepers and cell phones.

Methamphetamine and GHB are sold hand to hand via acquaintance networks. Most ecstasy is sold around schools via acquaintance networks, typically before the drugs are used in nightclubs and bars.

According to the epidemiologic source:

Buyers collect lists of phone numbers of active heroin and cocaine dealers. When buyers want these drugs, they call a dealer to arrange a meeting for the exchange of the drug indoors.

In the central city, heroin and powder cocaine sales take place in open-air markets, but these markets have become decentralized in the past few years. Thus, the introduction of beepers and cell phones to set up meetings between buyers and sellers in public places has occurred. In the suburbs, meetings for the exchange of powder cocaine are more "casual" and take place almost exclusively in apartments.

Marijuana and ecstasy sales are similar to the delivery method for heroin and cocaine sales, but meetings for the exchange of marijuana and ecstasy usually take place in private residences of buyers or sellers.

WHO SELLS DRUGS?

The law enforcement source states that most drug sellers in Boston are independent adults who sell only one type of drug.

The epidemiologic source states that heroin and powder and crack cocaine sellers fall into two groups: independent adults older than 30 and organized young adults, with an increase in the numbers of independent sellers and addicts who support their habits via drug sales. Over the past 2 years, polydrug sellers (typically of heroin, crack, and powder cocaine) have increased.

Marijuana, ecstasy, and diverted OxyContin® sellers are independent young adults.[E]

How is OxyContin® diverted and sold illegally?

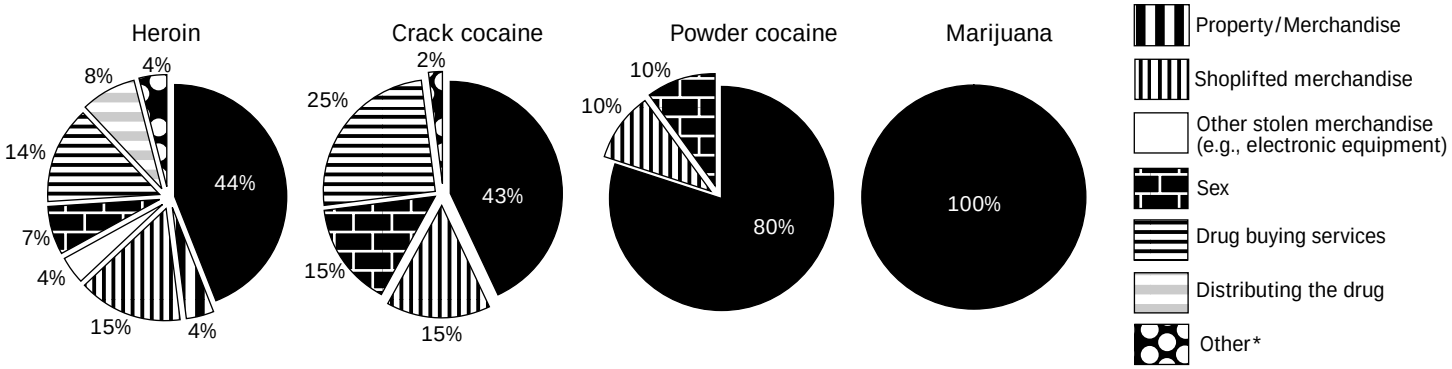
OxyContin® is diverted in a variety of ways:

- Unscrupulous doctors, some who exchange OxyContin® prescriptions for sex[L,E]
- "Doctor shopping"[L]
- Doctors who misprescribe the drug[L]
- Pharmacy robberies[L]
- Falsified prescriptions[L]
- Prescription thefts from individuals[L]

Additionally, OxyContin® is obtained from local health providers who prescribe it to people with legitimate ailments. These people use part of the drug and sell part of it illegally.[N] A new way to divert OxyContin® has emerged in fall 2002: well-dressed people pose as prospective real estate clients. When a real estate agent shows a "client" a house, the client rifles through medicine cabinets to steal OxyContin®.[L]

Fortunately, pharmacy robberies continue to decline, and many pharmacies now display signs stating that they no longer sell OxyContin®.[L,E,N]

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



- *As in most* Pulse Check *cities, cash is the most common means of exchange for illegal drugs in Boston. However, drug buying services, shoplifted merchandise, and sex are relatively prevalent as modes of exchange for heroin and crack cocaine.*
- *The ethnographic source notes that shoplifted merchandise is usually exchanged for cash, which is then used to buy illegal drugs.*[E]

** "Other" includes items accounting for 2 percent or less of transactions for each of the five drugs, such as transporting the drug, stealing the drug, food stamps, and injecting services.*

Source: Mean of response ratings given by epidemiologic/ethnographic and methadone treatment respondents; the methadone treatment respondent provided percentages only for heroin exchanges.

How much does South American heroin* cost?

Unit	Price
One bindle (0.1 g)	$4–$6[L]
One bag	$10[M]
0.5 g	$50–$75[E]
One bundle (10 bags)	$80[E]
1 g	$80–$150[E]

**Purity 60–96%*[L,E]

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

- *Between spring and fall 2002, the most common unit of heroin sold declined in quantity from 1 to 0.5 grams.*[E]
- *Smaller quantities of heroin declined in price (from $100–$150 to $80–$150 per gram). This may be a marketing ploy for new buyers.*[E]
- *Over the last 10 years, heroin prices declined (from $20 to $10 per bag—a lower price than for prescription opiate pills).*[M]

How much does cocaine cost?

Form	Unit	Price
Crack	One "jum" (small rock, 0.1 g	$10[L]
	One "bump," "jum" (approximately four hits)	$20–$40[E]
	1 g	$50–$60[E]
Powder	0.25 g	$20[E]
	1 g	$50–$60[E]
	Eightball (4 g)	$200–$250[L]

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

Crack and powder cocaine prices remained relatively stable between spring and fall 2002.[L,E]

How much does marijuana cost?

Unit	Price
0.125 oz	$20[E]
0.33-oz bag	$50[E]
1 oz	$100–$125[E] $325[L]

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

- *Marijuana prices increased dramatically since the last* Pulse Check.[L]
- *The number of indoor grows ("hydrogrows"), the amount of marijuana grown, and the level of THC continues to increase.*[L]

How much do various other drugs cost?

Drug	Unit	Price
Methamphetamine	1 g	$100[L]
Ecstasy	One pill or tablet	$20–$25[L,E]
Diverted OxyContin®	20-mg pill 80-mg pill	$10–$20[E] $80[L]
Oxycodone (Percocet®)	5-mg pill	$5[E]
Special K	One capful One bottle (1 oz)	$5[L] $50[L]

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

- *Nearly all prices for other drugs remained stable.*
- *Although ecstasy prices are stable, undercover officers "continue to see more of it."*[L]

Which drug sellers are associated with which crimes?

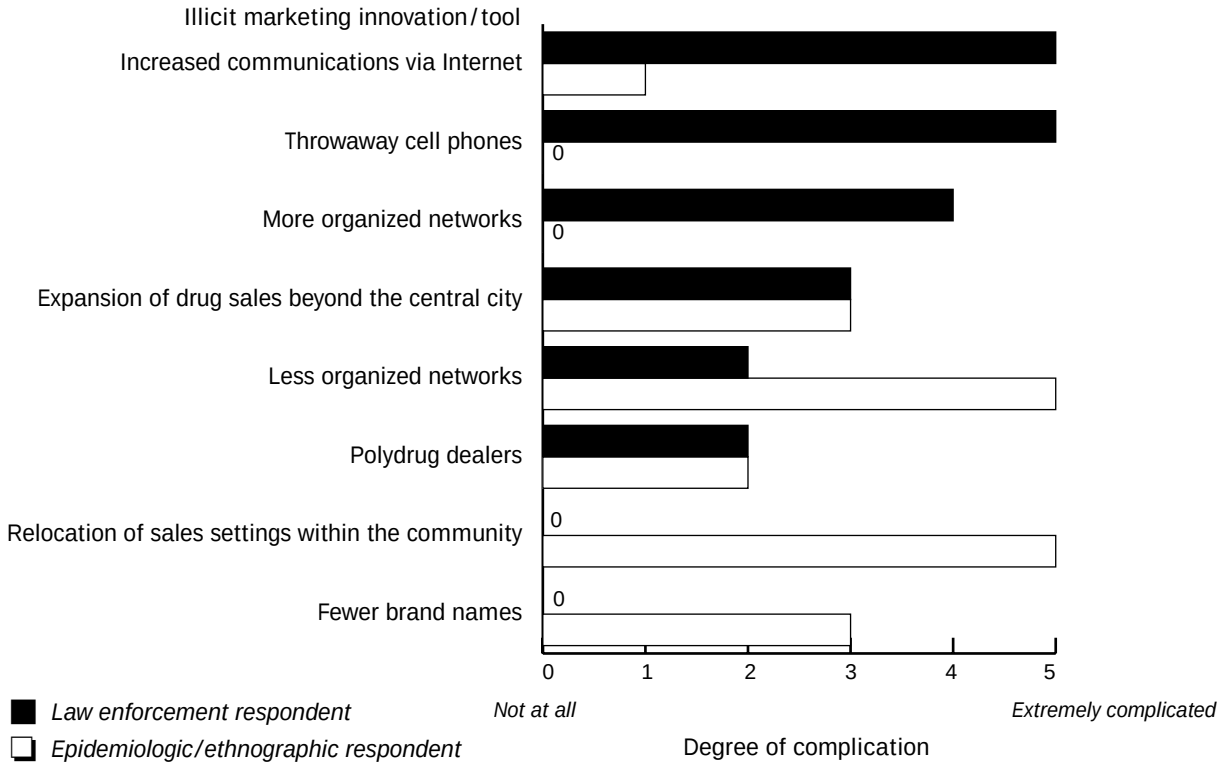
Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Metham-phetamine	Ecstasy	Diverted OxyContin®
Prostitution	✓	✓	✓				
Gang-related activity	✓	✓	✓				
Violent criminal acts (armed robbery, assault and battery, extortion)	✓	✓	✓		✓		✓
Nonviolent criminal acts: (shoplifting, petty theft, petty embezzling[E]; robberies, prescription theft, larceny, forged prescriptions[L])		✓		✓		✓	✓
Domestic violence	✓	✓	✓		✓		
Drug-assisted rape					✓		
No crimes associated				✓		✓	

Sources: Law enforcement and epidemiologic/ethnographic respondents

- *Illegal drug sales in Boston are associated with a wide variety of crimes, including prostitution, gang-related activity, armed robbery, extortion, assault, petty theft, shoplifting, larceny, and domestic violence.*[L,E]
- *Crack dealers (especially young adults) are more involved in crimes than any other drug dealers.*[E]

THE MARKET PERSPECTIVE: A 10–YEAR VIEW

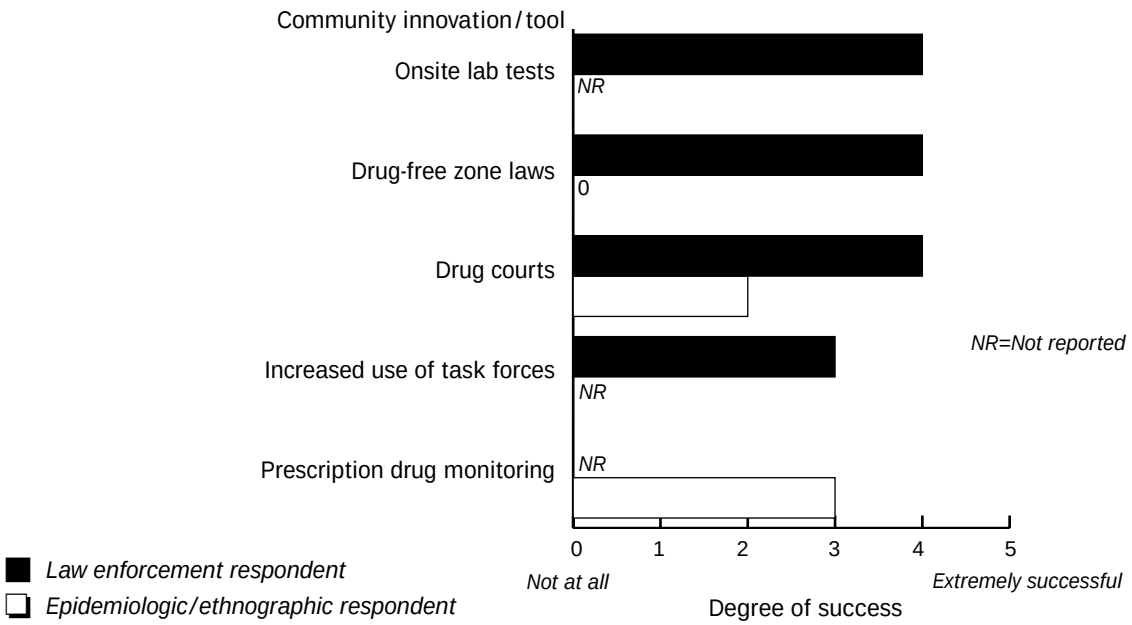
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Boston?



What they have to say...

- *Less organized networks: Networks are more fragmented now, which has led to fewer police informants.*[E]
- *Fewer brand names: The decline in the use of brand names for illegal drugs has made it more difficult for law enforcement to connect certain drugs to specific dealers.*[E]
- *Polydrug dealers: As reported in the "Who Sells Drugs?" section, dealers who sell both heroin and cocaine have increased over the past 2 years.*[E]

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



What they have to say...

- *Task forces: Although task force use has not increased over the past 10 years, task forces include interaction between local and State police, the Federal Bureau of Investigation (FBI), and the Drug Enforcement Administration (DEA). As in most other* Pulse Check *cities, the law enforcement source rates task forces as relatively successful in combating drug abuse.*
- *Prescription drug monitoring: OxyContin® has become harder to obtain from pharmacies due to the increased attention paid to the problem by pharmacists.*[E]
- *Drug courts: The epidemiologic source believes that drug courts are especially effective for middle class people with low levels of drug dependency, solid support systems, high education levels, and high chances of employment.*[E]

SEPTEMBER 11 FOLLOWUP

All four Boston *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no effects on the drug abuse problem.[L,E,N,M]