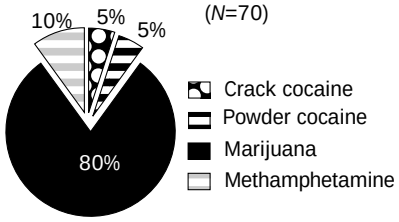
MINNEAPOLIS/ST. PAUL METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 2,968,806
- Median age: . . . . . 34.2 years
- Race (alone):
  - White 86.1%
  - Black 5.3%
  - American Indian/ Alaska Native 0.7%
  - Asian/Pacific Islander 4.1%
  - Other race 1.6%
  - Two or more races 2.1%
- Hispanic (of any race): . . . 3.3%
- Unemployment rate: 3.5%
- Median household income: $54,304
- Families below poverty level with children <18 years: 6.5%

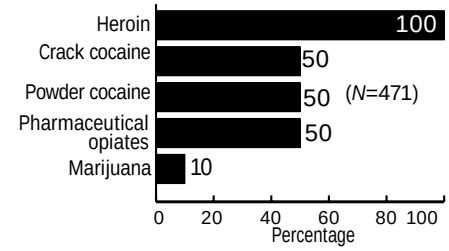
*Source: U.S. Census 2000**

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 use+? (Fall 2002)



+Includes any use, whether as a primary, secondary, or tertiary drug; program does not test for marijuana, so figure is based on self-reports; pharmaceutical opiates include hydromorphone (Dilaudid®), butorphanol tartrate (Stadol®), hydrocodone (Vicodin®), and oxycodone (Percodan®, Percocet®).

Source: Methadone treatment respondent

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

Two of the *Pulse Check* sources believe that the area's overall drug problem has remained stable,[E,N] while the other two believe it has worsened somewhat.[L,M] Specifically, several developments are reported:

- Heroin, crack and powder cocaine, marijuana, and methamphetamine are being sold on the streets or in open-air markets—a major development over the past few years in a metropolitan area that never used to have a street scene.[L,E]
- As mentioned in eight other *Pulse Check* cities, diverted methadone is an emerging problem.[M] Local pain clinics have been shifting from prescribing OxyContin® (oxycodone hydrochloride controlled-released) to prescribing methadone. Many patients referred from methadone treatment to a higher level of care go, instead, to pain clinics, feigning pain. Physicians at these clinics then prescribe the drug—not because they are unscrupulous, but because they are naive in identifying people with coexisting opioid problems.
- Cooking methamphetamine in rented hotel rooms and in cars is a recently increasing trend.[L]
- Undercover police find it easier to purchase BC bud (British Columbian marijuana) since the previous reporting period because of a new pipeline to Seattle.[L] Three other sources in *Pulse Check* cities report a similar change (Seattle,[L] St. Louis,[E] and Portland, OR[L]). While marijuana dealers tend to operate independently, recent gang activity is also reported in relation to BC bud—again, similar to reports in Seattle.[L]
- The use of "sherms" and "water" (phencyclidine [PCP], embalming fluid, and marijuana combined) has increased over the past few months (similar to an increase reported in Houston[E]), according to methadone patients in a small telephone focus group jointly conducted by the methadone treatment source and the *Pulse Check* discussant.[F] The epidemiologic source also reports an increase in this combination ("wet sticks" or "dipped joints").[E]
- Khat is an emerging drug among the area's Somalian community, which is the largest in the country.[L]
- An increase is reported in pills sold as "ecstasy" that actually contain no methylenedioxymethamphetamine (MDMA).[E]

Three of the *Pulse Check* sources believe the area's overall drug problem is very serious, while one[M] describes it as "somewhere between somewhat and not very serious." Because of the different perspective each brings, the sources vary in their perception of which drugs are most commonly abused and which have the most serious consequences. For example, the law enforcement source considers crack the drug related to the most serious consequences because of its association with homicides. Similarly, the methadone treatment source

Spring vs fall 2002...

- *Crack and methamphetamine increased slightly as primary drugs of abuse in the non-methadone program.*
- *Treatment percentages in the methadone program remained relatively stable.*

**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 *(continued)*

considers benzodiazepines the drugs with the most serious consequences second to heroin, because of their involvement in overdoses when combined with opiates, and also names cocaine, because of its involvement in crime.

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

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

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

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

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

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

Drug related to the second most serious consequences:
- Heroin[L]
- Marijuana[E]
- Methamphetamine[N,F]
- Benzodiazepines, cocaine[M]

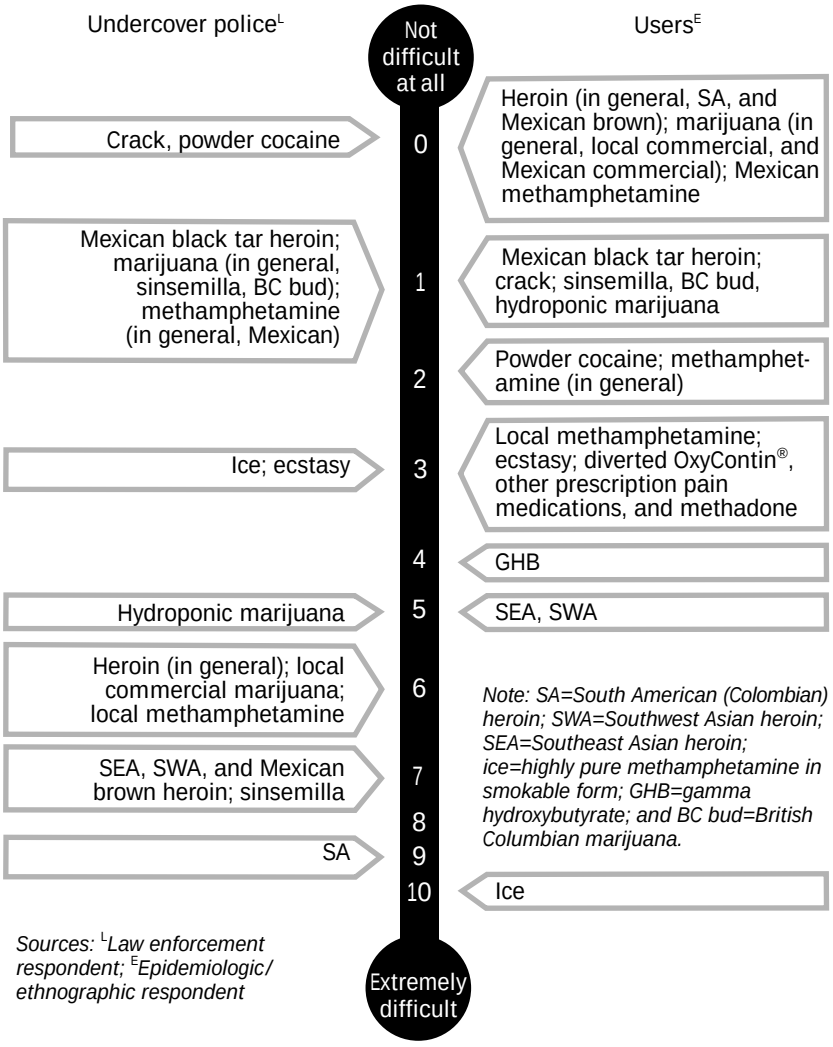
No reported changes between spring and fall 2002[L,E,N,M]

New or emerging problems:
- Khat[L]
- Diverted/abused prescription pain medications[E]
- Ecstasy[N]
- Methadone diverted from pain clinics[M]
- "Sherms" and "water" (PCP + embalming fluid + marijuana)[F]

Sources: [L]Law enforcement, [E]Epidemiologic/ethnographic, [N]Non-methadone treatment, [M]Methadone treatment, and [F]Focus group 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; GHB=gamma hydroxybutyrate; and BC bud=British Columbian marijuana.

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

- *Minneapolis/St. Paul is one of eight* Pulse Check *cities where users can purchase heroin (in general) with no difficulty at all. It is also one of five cities where users can purchase Mexican methamphetamine with no difficulty at all.*[E]
- *BC bud is fairly easy to purchase, by both users and undercover police, as is the case in only a handful of other* Pulse Check *cities.*
- *Undercover police find it less difficult to purchase BC bud since the previous reporting period because of a new pipeline to Seattle.*[L] *Only three other cities report a similar change (Seattle,*[L] *St. Louis,*[E] *and Portland, OR*[L]*).*
- *Users and undercover police can purchase most drugs with a fairly similar degree of ease, with two exceptions: users find it more difficult than undercover police to purchase ice; conversely, undercover police find it more difficult than users to purchase SA and Mexican brown heroin.*
- *Users find it less difficult to purchase diverted prescription pain medications in fall 2002 than in the previous spring.*[E]

HEROIN

- Purity has increased, price is low, and supplies are plentiful.[E,M]
- Opiate-related deaths continue to increase, recently surpassing cocaine-related deaths for the first time.[E]
- Increases are reported in overdoses, smoking and snorting, and use in the suburbs.[E]
- Street sales have increased. The area never used to have a street scene.[E]

COCAINE

- While crack is readily available, and it increased slightly as a primary drug of abuse between spring and fall 2002, it is "an adult drug. Kids look down on it." The few adolescents who use it tend to be hooked up with older people and have moved off the street and into the business.[N]
- The number of crack users has declined somewhat, among both younger and older adults.[E]
- The number of clients in treatment for powder cocaine abuse has remained stable.[N]

MARIJUANA

- The number of marijuana users has increased somewhat among younger and older adolescents.[E]
- More people are in treatment for marijuana than for other drugs.[E]
- Minneapolis/St. Paul has the highest marijuana-positive arrestee urinalysis levels among all the cities in the Arrestee Drug Abuse Monitoring (ADAM) program.
- Marijuana use has increased in the suburbs.[E]
- The use of marijuana combined with PCP and formaldehyde ("wet sticks" or "dipped joints") has increased.[E]

METHAMPHETAMINE

- According to high school counselors, use is moving into younger age groups.[E]
- The percentage of clients who are methamphetamine users has increased somewhat.[N]

MDMA (ECSTASY)

- The number of ecstasy users has increased somewhat.[E]
- Use is increasing in both suburban and rural areas.[E]
- The percentage of clients who use ecstasy as a secondary or tertiary drug has increased sharply (to 30 percent), both in the general treatment population and among first-time clients.[N]

DIVERTED OXYCONTIN®

- Diverted OxyContin® is increasingly mentioned in emergency department, medical examiner, poison control, and law enforcement data.[E]
- While 90 percent of abusers are White, American Indians are overrepresented at 10 percent. Users tend to be older than 30 and reside in central city, suburban, and rural areas. Injecting is the primary route of administration.[E]
- For the first time, 5 percent of new clients in the methadone program abuse OxyContin® as their primary drug, and 10 percent abuse it as a primary, secondary, or tertiary drug. Further, among intakes (not regular clients), about one-third of pharmaceutical addicts abuse OxyContin®. These individuals are middle-class suburban "medical addicts, not street people," who take the drug orally and get it through physicians at pain clinics.[M]

OTHER DRUGS

- Misuse of pain medication was diagnosed in a series of 44 pain clinic patients who entered methadone treatment. Their problems included "lost" prescriptions, early prescription refills, and unsuccessful pain treatment. About half of them subsequently dropped out of the pain clinics, indicating that they have addictive disorders and are using the methadone as a substitute.
- Abuse of other pharmaceutical opiates, including hydromorphone (Dilaudid®), butorphanol tartrate (Stadol®), hydrocodone (Vicodin®), and oxycodone formulations (Percodan® and Percocet®) accounts for a steady 15 percent of primary drug problems in the methadone program. The majority (60 percent) of these clients are female.[M]
- Opium is shipped from California once a month to the area's large Hmong refugee population, many of whom use welfare checks to support their $250-per-month habit.[M]
- Khat is overnight-mailed or shipped in luggage on airplanes from Kenya to Somali refugees in the Minneapolis/St. Paul area. This natural stimulant, which loses potency in 48 hours, has leaves that contain psychoactive ingredients structurally and chemically similar to d-amphetamine.[E]

- Gamma hydroxtbutyrate (GHB) and ketamine continue to be used by White, sophisticated, suburban "clubbers," although they are occasionally used in the central city. GHB is part of the weekend rave drug culture among a group of young gay males.[M]
- Flunitrazepam (Rohypnol) is occasionally, but more rarely, used by clubbers.[N]
- Lysergic acid diethylamide (LSD) use, which rebounded in the 1990s, continues a low upward trend. Once used primarily by Whites, it is now getting into other racial/ethnic groups.[N]
- PCP is "out there," but the large supplies of LSD might detract from its use.[N]
- Methylphenidate (Ritalin®) is sold to friends by adolescents who have legitimate prescriptions. Cells of adolescent users crush and snort the pharmaceutical.[N]
- Ephedra-based drugs are combined experimentally with other drugs. Users tend to be White and sometimes hook up with methamphetamine dealers or producers who get them supplies.[N]
- Other substances: Five different area school counselors report that youth scrape off sulfuric acid that has accumulated on car batteries, roll it, and smoke it. They call it "lithium." Snorting Kool Aid® is another practice reported in schools.

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- Treatment capacity and availability: At the time of the *Pulse Check* discussion, the non-methadone treatment respondent's program was operating slightly under its capacity of 85 beds. This program serves adolescent boys, accounting for the high percentage of marijuana and the absence of heroin as a primary drug of abuse (*see pie chart on the first page of this report*). Because its demographics represent the school system population, this program is well positioned to alert the community to new and emerging drug problems and user groups.[N] The methadone treatment respondent is with a two-site program operating slightly under its capacity of 500 (which is a staffing criterion, based on historical experience with neighbors, logistics, and caseloads).[M] While all clients at the program use heroin, large proportions also use crack, powder cocaine, or prescription opiates (*see bar chart on the first page of this report*). Furthermore, sometimes those drugs are the primary drugs of abuse, rather than heroin.

  Methadone maintenance treatment is available throughout the Minneapolis/St. Paul area. Treatment availability in public programs has remained stable between spring and fall 2002, but fewer slots are available in private programs. Both public and private programs have adequate capacity.[E]
- Recidivism: In the non-methadone program, 50 percent of crack clients, 33 percent of powder cocaine clients, 25 percent of marijuana clients, and 10 percent of methamphetamine clients are return clients.[N] In the methadone program, 98 percent of the heroin clients have had prior non-methadone treatment, and 70 percent have had prior methadone treatment.[M]
- Women in treatment: While nearly half of the heroin clients in this program are female, most other programs have a 3:1 male-to-female ratio.[M] Women are more interested in full-service hospital-based programs than other community-based programs.[M]
- Marijuana use: More people in the area are in treatment for marijuana than for any other drug.
- Consequences of drug use: One treatment source notes that high-risk pregnancies are stable at high levels, elaborating that five to eight boys in treatment at any time are fathers or prospective fathers. Many of those teens have multiple children from multiple mothers.[N]

  Criminal behavior has increased as a result of drugs: Younger teens are committing more serious offenses—something not seen 5 years ago. They act out and are involved in car theft, gang activity, guns in school, violence in school, drive-by shootings, and drug sales. These youth are increasingly certified as adults and are treated as such in the criminal justice system.[N]

  Methadone overdoses doubled (from 6 to 12) in the last year.[M]
- Co-occurring disorders: Antisocial disorders or conduct disorders are the most common co-occurring disorders among the adolescents in this program.[N] Mood disorders have increased, as have suicidal thoughts. In the past year, two adolescents (not in the program) committed suicide.[N] Mood disorders in the other *Pulse Check* source's program[M] are stable at a high rate (41 percent of people at admission). The hepatitis C rate has

increased to 92 percent now that the program is testing for the disease. Tuberculosis cases increased (from 0 to 6), mostly among Hmong clients. Diagnoses of other serious medical conditions are stable at high levels in this aging population, with advanced cases of diabetes, liver disease, and other age-related comorbidity. The program recently began assessing clients for chronic pain, which has increased.[M]

- Barriers to treatment: The most serious barrier is the delay prior to treatment: with the current 2- to 4-week referral process, many drug users drop off before their number comes up.[M] Many adolescent drug users have low-income working parents with inadequate insurance that prohibits treatment. Others are from families with no insurance, and some have no permanent address, move frequently, live in shelters, and frequent soup kitchens.[N]
- Changes over the past 10 years: The largest changes include the following: the increase in polydrug use, which makes it hard to "get to the bottom of what they're using";[N] the increased availability and purity of heroin, its declining cost,[M] and the corresponding use of smokable heroin by young adults;[N] the advent of designer drugs, such as ecstasy and GHB;[N] and the increase in methamphetamine.

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 depict any emerging user groups and to report on how the drugs are used. As shown in 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.

- *Heroin use in the suburbs has increased slightly.*[E]
- *While nearly half of the heroin clients in this program are female, most other programs have a 3:1 male-to-female ratio. Women appear more interested in full-service hospital-based programs than other community based programs.*[M]

Who's most likely to use heroin?

Characteristic	E	M
Age group (years)	>30	>30
Mean age (years)	35	42
Gender	70% male	53% male
Race/ethnicity	White	White
Socioeconomic status	NR	Low
Residence	Central city	All areas
Referral source	N/A	County assessment
Level of education completed	N/A	High school
Employment at intake	N/A	Unemployed

Note: Heroin is not a drug of abuse at the non-methadone program, which serves adolescent boys.

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

How do users take heroin?

Characteristic	E	M
Primary route of administration	Injecting	Snorting
Other drugs taken	Powder cocaine (speedballs), methadone	Benzodiazepines
Publicly or privately?	Privately	Privately
Alone or in groups?	Alone	Alone

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

- *Injecting has declined, while snorting and smoking have increased.*[E]
- *Methadone overdoses have increased.*[E]
- *Heroin injectors use in networks of 4–6 users.*[M]
- *Clonazepam (Klonopin®, or "pins") is the most commonly used benzodiazepine.*[M]

Who's most likely to use cocaine?

Characteristic	Crack			Powder cocaine		
	E	N	M	E	N	M
Age group (years)	>30	13–17*	>30	>30	13–17*	>30
Mean age (years)	31	17*	42	34	16*	42
Gender	70% male	100% male*	53% male	70% male	100% male*	53% male
Race/ethnicity	Black	Black	White	50% White, 50% Black	All	White
Socioeconomic status	NR	Low	Low	NR	Low/Middle	Low
Residence	Central city	Central city	All areas	All areas	Suburbs	All areas
Referral source	N/A	Criminal justice	County assessment	N/A	Criminal justice	County assessment
Level of education completed	N/A	Junior high	High school	N/A	Junior high	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Full-time student	Unemployed

**The non-methadone program serves adolescent boys.*

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

- *The percentage of crack users has declined somewhat, among both younger and older adults.*[E]
- *Among first-time admissions, the percentage in treatment for crack has declined somewhat. Among the overall treatment population, the percentage for crack has increased slightly, but the numbers are low. The percentage of clients in treatment for powder cocaine abuse has remained stable.*[N]
- *While crack is readily available, it is "an adult drug. Kids look down on it." The few adolescents who use it tend to be hooked up with older people, and have moved off the street and into the business.*[N]
- *Crack and powder cocaine as primary drugs of abuse each account for 12.5 percent of clients in the methadone program. These percentages have remained stable.*[M] *However, focus group participants from that program believe that powder cocaine snorting and injecting have increased, while crack use has declined. They attribute this change to the declining cost and increasing purity of powder cocaine.*[F]
- *Among powder cocaine users, Whites are underrepresented and Blacks are overrepresented relative to the general population.*[E]
- *Among methadone clients, a higher percentage of primary cocaine (crack and powder) are Blacks than among primary heroin users.*[M]
- *While powder cocaine is usually snorted, smoking has increased.*[E] *Both snorting and smoking are reported among powder cocaine users in treatment.*[N]
- *Crack is often combined with marijuana, while powder cocaine is combined with heroin in speedballs.*[E] *Powder cocaine users in treatment combine the drug with marijuana.*[N]
- *Crack users in the methadone program take a "high dose of methadone plus crack on the side."*[F] *Powder cocaine users in the program inject that drug with heroin, stating, "You can't 'blow' [inject heroin] without a 'mo' [powder cocaine]."*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–17	13–17*	>30
Mean age (years)	15	NR	NR
Gender	Evenly split	100% male*	75% male
Race/ethnicity	White	White	White
Socioeconomic status	Middle	Low/middle	Low
Residence	Suburbs, rural areas	Central city, suburbs	All areas
Referral source	N/A	Criminal justice	County assessment
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	Full-time student	Unemployed

**The non-methadone program serves adolescent boys.*

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

- *The number of marijuana users has increased somewhat, among both younger and older adolescents.*[E]
- *More people are in treatment for marijuana than for other drugs.*[E]
- *Marijuana use has increased in the suburbs.*[E]
- *While Whites predominate, marijuana use crosses all races/ethnicities.*[N]
- *Treatment percentages remain stable for primary, secondary, and tertiary marijuana use.*[N,M]

- *The use of marijuana combined with PCP and embalming fluid ("wet sticks" or "dipped joints") has increased.*[E]
- *Methadone clients who use marijuana do not take other drugs. Most are successfully recovering, functional methadone patients.*

How do users take marijuana?

Characteristic	E	N	M
Primary delivery vehicle	"One-hitter pipes"	"One-hitter bongs"	Joints
Other drugs taken	PCP and embalming fluid	"Crank" (methamphetamine), hashish, opium, PCP, embalming fluid	None
Publicly or privately?	Both	Both	Privately
Alone or in groups?	In groups/ among friends	Both	Alone

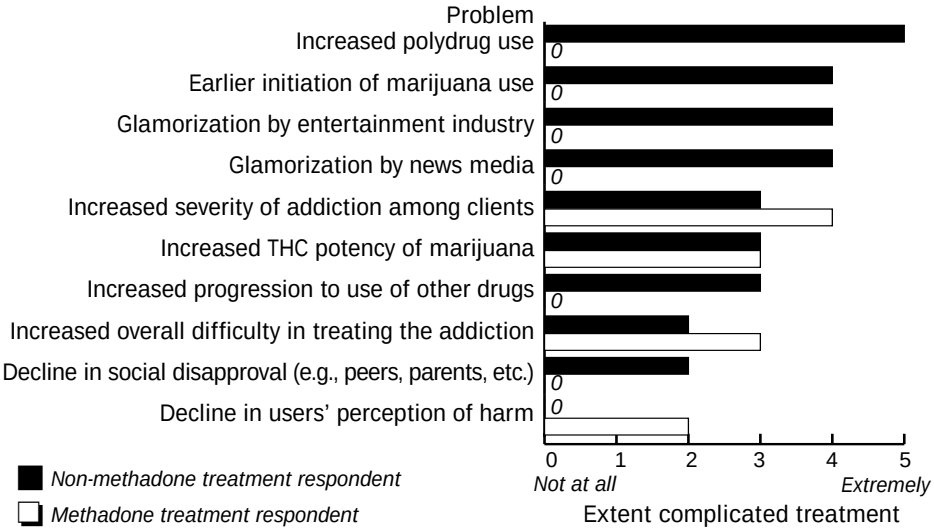
Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

One source lists "amotivational syndrome" as a negative consequence of marijuana use, describing users with this syndrome as "underemployed, inactive, using marijuana as a substitute for hobbies or social activities, and generally not doing as well in life as they should be doing." Additionally, respondents associate marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:

- Drug-related emergency room visits[E,N]
- Drug-related arrests[E,N]
- Automobile accidents[E,N]
- High-risk pregnancies[E,N]
- Short-term memory loss [N]
- Deteriorating family/social relationships[E,N]
- Poor academic performance[E,N]
- School absenteeism or truancy[E,N]
- Dropping out of school[E,N]
- Poor workplace performance[E,N]
- Workplace absenteeism[E,N]

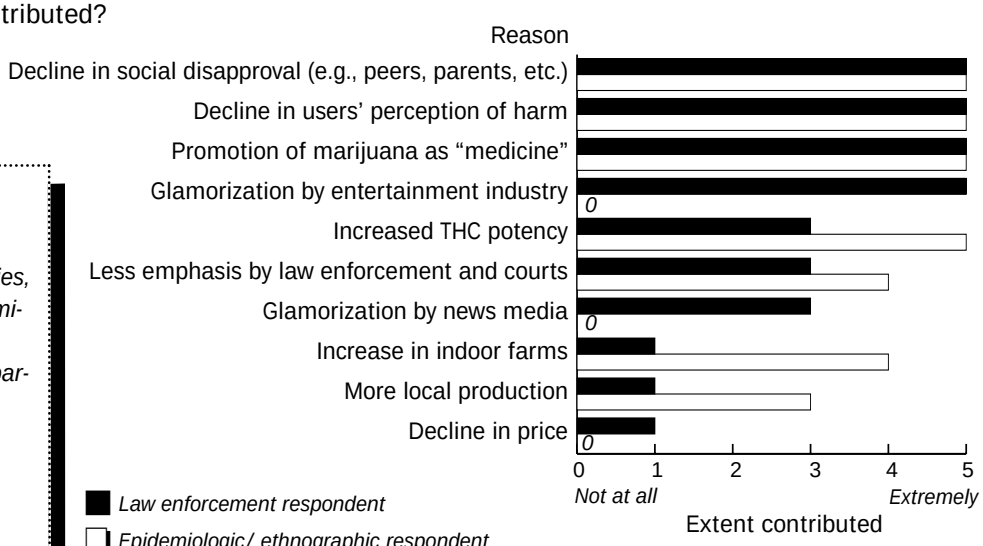
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

- *Marijuana potency has increased only moderately compared with 10 years ago, but it has increased sharply compared with 20 years ago.*[N]
- *The non-methadone respondent attributes greater impact to the news media's glamorization of marijuana than do the majority of respondents in other* Pulse Check *cities.*
- *In general, changes over the past decade seem to have had greater impact on marijuana users in the non-methadone program than those in the methadone program.*

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



What they have to say...

- *In agreement with the majority of respondents in other* Pulse Check *cities, both the law enforcement and epidemiologic respondents believe that three changes over the past decade have particularly contributed to marijuana's widespread availability and use: the decline in social disapproval, the decline in users' perception of harm, and the promotion of marijuana as "medicine."*[L,E]
- *While the decline in users' perception of harm has had a huge impact over the past 10 years, this perception has been stable for the past 3 years.*[E]
- *Mainstream media, particularly magazines that target youth, have perpetuated the public debate regarding the harmfulness of marijuana. By exploring the issue in debate form, rather than presenting the scientific facts, they have contributed greatly to the widespread use of marijuana.*[E]
- *Indoor farms have had an impact because, outdoor farming is difficult with the short growing season.*[E]
- *Promotion of hemp products to youth has also contributed greatly to widespread marijuana use and availability.*[E]
- *As in the majority of* Pulse Check *cities, declining price has not affected use or availability. On the contrary, most prices have remained stable over the past 10 years, and some have actually gone up.*[L,E]

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	18–30	13–17*
Mean age (years)	27	NR
Gender	60% male	100% male
Race/ethnicity	White	White
Socioeconomic status	NR	Low, middle
Residence	Suburbs, rural areas	Central city, suburbs
Referral source	N/A	Criminal justice
Level of education completed	N/A	Junior high
Employment at intake	N/A	Unemployed or full-time student

**The non-methadone program serves adolescent boys.*

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

- *The percentage of clients who are methamphetamine users has increased somewhat.*[N]
- *According to high school counselors, use is moving into younger age groups.*[E]
- *The new group of adolescent users includes an equal number of girls and boys.*[E]
- *While methamphetamine-using clients are predominantly White, a large proportion of the program's Hmong population also use the drug.*[N] *(The Minneapolis/St. Paul area has the Nation's largest Hmong population, and one-third of the program's clients are of that race/ethnicity.)*[N]

- *Methadone clients generally do not use methamphetamine.*[M]
- *Smoking is generally the primary route of administration.*[E] *Eighty percent of the methamphetamine-using clients smoke the drug; the other 20 percent snort it.*[N]
- *Snorting methamphetamine is known as "getting glassed."*[E]

Who's most likely to use ecstasy?

Ecstasy users are predominantly young (13–17 years) White males (about 60 percent) who live in central city, suburban, and rural areas.[E,N] While ecstasy-using clients are primarily White, the program has a fair representation of Blacks, Hispanics, and Asian/Pacific Islanders.[N] No ecstasy users are reported in the methadone program.[M] A few changes are reported:

- The number of ecstasy users has increased somewhat.[E]
- Use is increasing in both suburban and rural areas.[E]
- The percentage of clients who use ecstasy as a secondary or tertiary drug has increased sharply (to 30 percent), both in the general treatment population and among first-time clients.[N]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, crack, and powder cocaine are sold in central city and suburban areas. Marijuana, methamphetamine, and ecstasy are also sold in those areas, and in rural areas as well. Diverted OxyContin® is sold in central city and rural areas.

The law enforcement and epidemiologic sources agree that heroin, crack and powder cocaine, marijuana, and methamphetamine are all sold on the streets or in open-air markets—a major development over the past few years in a metropolitan area that never used to have a street scene. Both sources also agree that those drugs, plus ecstasy, are sold in the following settings—most of which, according to the epidemiologic source, are also settings for drug use:

- Inside cars
- In private residences
- On college campuses
- In nightclubs and bars
- In playgrounds and parks

Heroin, crack, and powder cocaine are also sold in crack houses or shooting galleries; additionally, they are sold in shopping malls, at raves, and at concerts, as are marijuana and ecstasy; they are also sold in hotels and motels, as are methamphetamine and ecstasy; and they are sold in public housing developments, as is methamphetamine.

Methamphetamine is not just used and sold in rented hotel rooms and in cars: it is also cooked in those settings—another recently increasing trend.[L]

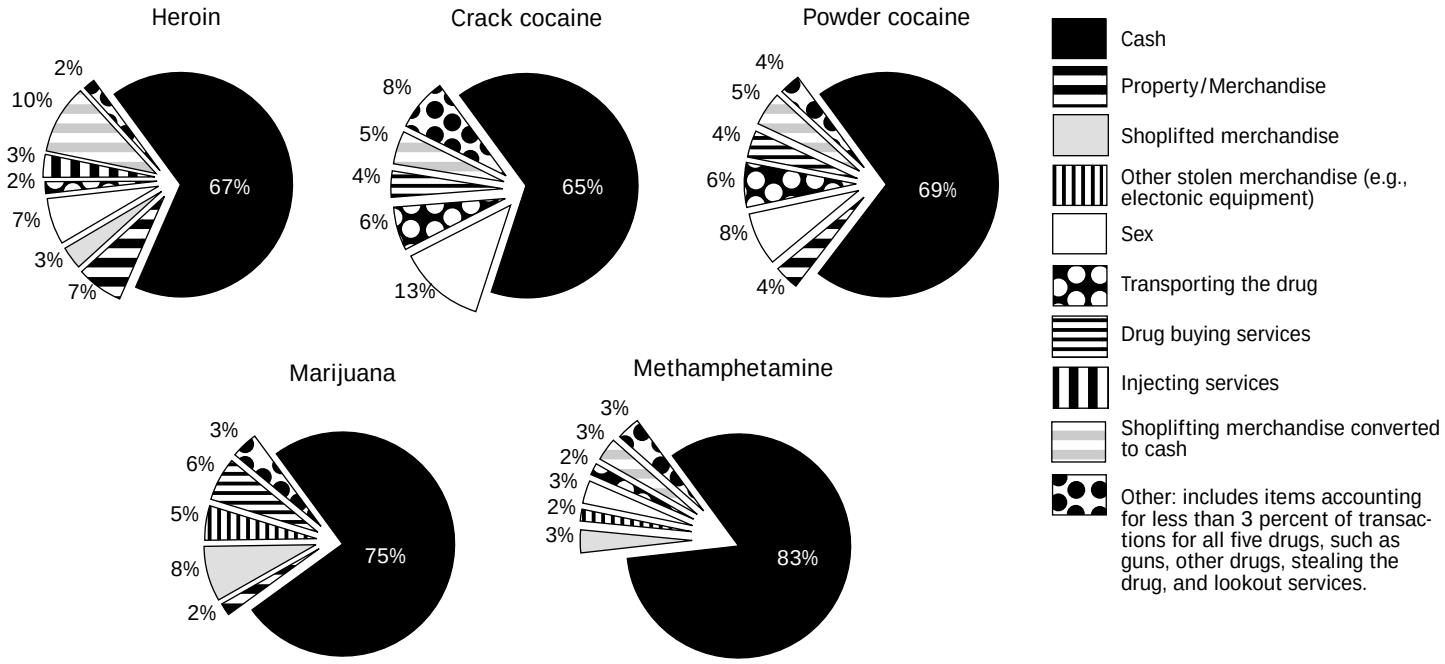
HOW DO DRUGS GET FROM SELLER TO BUYER?

- Heroin, crack, and powder cocaine can be purchased in several ways, including the following:[L]
  1. The buyer goes to a location known for the type of drug being sold (sometimes multiple drugs in one location) and asks someone where to find that particular drug.
  2. The buyer and seller then identify one another via eye contact or body language.
  3. The actual transaction is usually hand to hand.

  In the case of powder cocaine, the connection is also sometimes made in clubs. Sometimes cell phones or two-way communication devices are also involved.
- Marijuana and methamphetamine can be purchased similarly on the street, but they are also commonly obtained via acquaintance networks, word of mouth, and prearranged meetings.
- Ecstasy is obtained via word of mouth within a closed network, often at parties, sporting events, or school events. It is also purchased by mail or by dropoff in a public place.
- Diverted OxyContin® is obtained via word of mouth.
- GHB is obtained by word of mouth or via the Internet or e-mail.

As shown below, the majority of these transactions involve cash, especially in the case of methamphetamine. A variety of other commodities, however, are often exchanged—particularly in the case of crack and heroin.

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



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

What they have to say...

- *As drug use–especially of marijuana–has increased among young people over the last decade, shoplifting of items such as compact discs (CDs) has increased.*[E]
- *The exchange of sex for heroin has increased over the past 10 years.*[M]
- *Stolen farm equipment is often used in exchange for methamphetamine.*[E]
- *The exchange of stolen precursor chemicals for methamphetamine is a relatively new phenomenon.*[E]
- *While street-level transactions tend to be cash-only, at higher levels drugs are increasingly "fronted": a supplier typically gives a kilogram of a drug to a seller, who goes out and sells it, and then returns to the supplier with the cash payment.*[L]
- *An increase is reported in "ripping off" drugs from dealers or friends.*[N]
- *An increasing number of incidents involve teens who buy cars from crack addicts for small amounts of money (typically $50) and then go joyriding.*[N]
- *Hmong refugees use welfare checks to support their opium smoking–a $250-per-month habit. The drug comes from California once per month.*[M]

WHO'S SELLING DRUGS?

- **Heroin:**[L] Reports over the past year or two describe Nigerian sources coming through Chicago, as well as Mexican sources. Generally, heroin sellers still tend to operate independently and usually sell only heroin, although some sell powder cocaine. They are generally 20–40 years old, but some are in their forties. They are very likely to use their own drug.
- **Crack cocaine:**[L] All crack used to be processed locally by Black gangs; now, Mexicans cook up about 20 percent of the supply and sell it to the local gangs. These gang members are either adolescents or young adults who do not sell any other drugs and are somewhat likely to use their own drug.
- **Powder cocaine:**[L] Powder cocaine dealers are generally part of gangs or cartels. They are young adults who sometimes also sell methamphetamine and marijuana (and, in rare cases, heroin). They are very likely to use their own drug.
- **Marijuana:**[L] Marijuana dealers tend to operate independently, although recent gang activity is reported in connection to BC bud. Sellers are young adults who sometimes also sell powder cocaine. They are very likely to use their own drug.
- **Methamphetamine:**[L] Methamphetamine dealers are usually part of Mexican gangs. They are young adults who sometimes also sell powder cocaine. They are somewhat likely to use their own drug.
- **Ecstasy:**[L] Dealers are usually part of organized crime groups from Las Vegas, Los Angeles, and other big cities. They tend to be young adults who are somewhat likely to use their own drug. Sales activity has reportedly increased recently.

Which drug sellers are associated with which crimes?

Crime	Heroin	Powder cocaine	Crack	Marijuana	Methamphetamine	Ecstasy
Prostitution	✓	✓	✓			
Gang-related activity		✓	✓	✓		
Violent criminal acts	✓	✓	✓		✓	
Nonviolent criminal acts				✓	✓	✓
Domestic violence		✓				
Drug-assisted rape						✓

Source: Law enforcement respondent

Gang activity is generally associated with powder and crack cocaine. While marijuana dealers tend to operate independently, recent gang activity is reported in relation to BC bud.

How much does heroin cost?

Form	Unit	Price
Mexican	Bindle	$10–$50[E]
	Paper	$50[M]
	1 g	$300–$400[L]
Unspecified "powder"	NR	$20–$25[M]

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

- *Purity has increased, price has declined, and supply is plentiful, especially over the last year or two.*[E,M]
- *The gram price has increased since last year (from $200 to $300).*[L]

How much does cocaine cost?

Form	Unit	Price
Crack	Rock	$20[L,M]
	1 g	$100[L]
	1 oz	$900–$1,200[L]
Powder	1 g	$100[E]
	1 oz	$800–$1,200[L]
	1 kg	$20,000–$30,000[L]

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

- *All reported prices are stable between spring and fall 2002.*

How much does marijuana cost?

Form	Unit	Price
Local	Joint	$5[E]
	1.5 oz	$300[L]
	1 lb	$700[L]
BC bud	1 lb	$7,000–$12,000[L]

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

- *Prices listed in the table are stable between spring and fall 2002.*
- *Focus group participants believe that "weed" quality has increased, while the price has declined. A dime bag ($10) of hydroponic marijuana used to be enough for just one joint; now it has enough for two or three joints.*[F]

How much does methamphetamine cost?

Unit	Price
1 g	$100[L,E]
1 oz	$1,000[L]
1 lb	$12,000–$15,000[L]
1 kg	s$20,000–$30,000[L]

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

- *All reported prices are stable between spring and fall 2002.*
- *Adulteration with dimethylsulphone (DMSO, or "horse medicine") is stable.*[E]

How much do various other drugs cost?

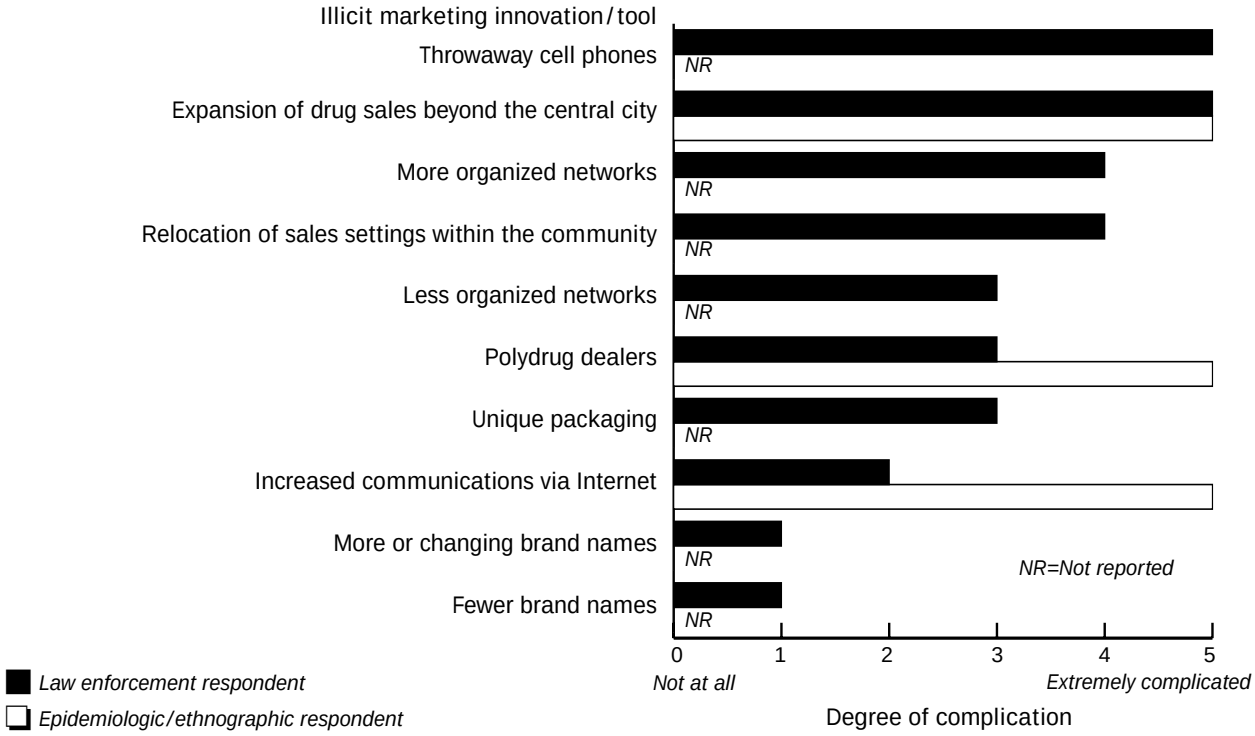
Drug	Unit	Price
Ecstasy	One pill	$20[L,E]
Diverted OxyContin®	1 mg	$1[E]
GHB	2 oz (2 dosage units)	$20[E]

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

- *An increase is reported in pills sold as "ecstasy" that actually contain no MDMA.*[E]
- *All reported prices are stable between spring and fall 2002.*

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

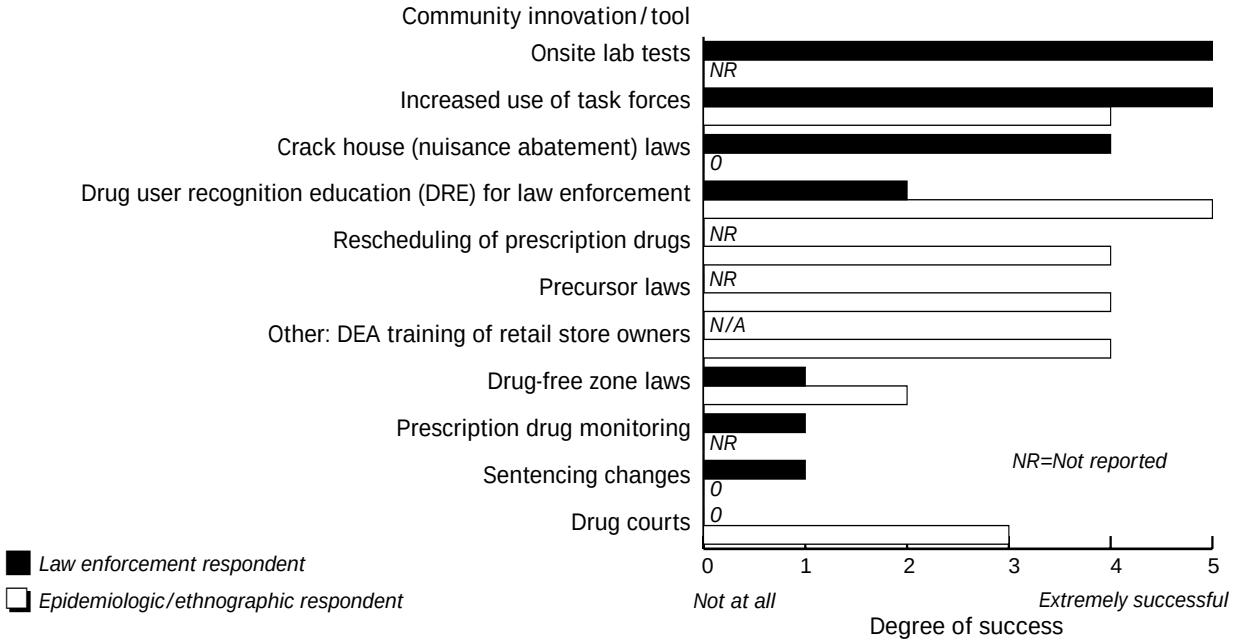
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Minneapolis/St. Paul?



What they have to say...

- *As in the majority of* Pulse Check *cities, the increased or decreased use of brand names by dealers has had little impact on law enforcement detection and disruption efforts.*[L]
- *Throwaway cell phones, by contrast, have posed a great challenge to market detection and disruption efforts—again, similar to reports in the majority of other* Pulse Check *cities.*[L]
- *One source believes that Internet communications have posed a great problem in market detection and disruption.*[E] *Another source, however, believes this effect is limited to club drugs.*[L]

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



What they have to say...

- *Task forces: The county sheriff's office and the Minneapolis Police Department pool their resources for large cases, such as wiretaps.*[L] *As drug sales move out of central city areas, more pooling of resources through multidisciplinary law enforcement task forces is enabling small towns to go after bigger dealers.*[E]
- *Precursor laws: Minnesota was one of the first States with laws on anhydrous ammonia.*[E] *Also, this source recommends encouraging retail sellers to voluntarily limit sales of pseudoephedrine and other ephedrine products.*[E]
- *Training of retail store owners: The DEA's extensive training of hardware and other retail store owners regarding meth lab ingredients and people who purchase them has significantly increased the reporting of suspicious activity to law enforcement.*[E]
- *Crack house (nuisance abatement) laws: One source believes these laws are not effective because crack houses are mobile and transitory.*[E] *Another believes that city ordinances have been effective, despite increased licensing issues. For example, a new ordinance requiring landlords to evict renters arrested on their property for narcotics charges is controversial, but it does move drug activity out.*[L]
- *Prescription drug monitoring: The Forgery Unit forwards cases to the Narcotics Unit, but more resources are needed to follow up.*[L]
- *Drug courts: The law enforcement source is one of the few* Pulse Check *respondents who believes drug courts to be ineffective, primarily because they treat users and dealers in the same way. Some dealers get four or five chances. Many cases are therefore prosecuted federally in order to avoid drug court.*[L] *The epidemiologic source considers drug courts somewhat more effective and recommends having an alcohol court.*[E]
- *Drug user recognition (DRE) for law enforcement: One source rates DRE in-service classes as minimally effective, stating that training could be improved if it were biannual and ongoing because of changing drug trends.*[L] *Another source rates DRE as highly effective and recommends expanding the training to more officers.*[E]

SEPTEMBER 11 FOLLOWUP

One source notes that during the first 6 months after September 11, 2001, increased border security slowed down the Mexican influx and drove up prices—but subsequently, everything went "back to normal."[L] Another believes that some of the best narcotics officers have been reassigned to Homeland Security.[E] During the *Pulse Check* discussion just before the war in Iraq, the methadone treatment source reported methadone patients hoarding the drug. One focus group participant elaborated: "People are scared, worried about the war, depressed." Another added: "People say, 'I'm going to die anyway, so I might as well have a good time.' Or maybe that's just an excuse..."