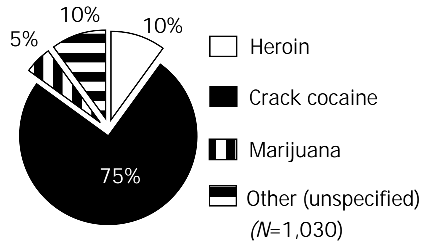
NEW YORK PRIMARY METROPOLITAN

STATISTICAL AREA PROFILE:

- Total population: . . . 9,314,235
- Median Age: . . . . . . 34.6 years
- Race (alone):
  - White: 48.8%
  - Black: 24.6%
  - American Indian/ Alaska Native: 0.5%
  - Asian/Pacific Islander: 9.2%
  - Other race: 12.3%
  - Two or more races: 4.6%
- Hispanic (of any race): 25.1%
- Unemployment rate: 5.1%
- Median household income: $41,053
- Families below poverty level with children <18 years: 23.3%

*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

Except for a slight increase in heroin as a primary drug of abuse, treatment percentages in this program remained relatively stable between spring and fall 2002.

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

All four *Pulse Check* sources believe the city's overall drug problem has remained stable, particularly the situation regarding cocaine, heroin, and marijuana.

Only a few changes are reported:

- The methadone treatment source believes that job opportunities have increased since 1996 legislation focused on work as part of recovery. Employment increased 75 percent at a model methadone program studied over a 3- to 4-year period.[M]
- Methamphetamine labs and seizures have increased.[L] New York is one of 15 *Pulse Check* cities where sources consider methamphetamine an emerging or intensifying problem. The numbers, however, are low.
- Methylenedioxymethamphetamine (MDMA or ecstasy) is making its initial appearance in the treatment population.[M] Massive pill shipments continue to be smuggled into the city.[L]
- The sale of diverted prescription drugs on the street is growing.
  - Uncontrolled substances, such as ulcer medications, are illegally sold in immigrant communities.[E]
  - Patients with human immunodeficiency virus (HIV) are selling their medications on the street, outside of hospitals and pharmacies.[E]

Additionally, the drug market is changing in a few ways:

- Polydrug sales, usually involving cocaine plus one other drug—such as heroin, ecstasy, marijuana, a diverted prescription drug, or ketamine—have been increasing over the past 2 years.[L]
- Traffickers are becoming more savvy in using the Internet and other communications technology to manage their business and stay one step ahead of the law.[L]
- One source believes that terrorism and drug trafficking are linked, and all groups are getting involved (for example, the illegal diversion of pseudoephedrine is linked to terrorist groups).[L]

All four sources consider the city's drug problem very serious, and they all believe crack remains the drug associated with the most serious consequences. Because of the different perspective each brings, the sources differ in their perception of which drug is most widely abused.

Most widely abused drug:
- Crack and powder cocaine[L]
- Marijuana[E]
- Crack[N]
- Heroin[M]

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

Second most widely abused drug:
- Synthetics (ecstasy, ketamine, PCP, LSD, GHB, and Rohypnol[L])
- Heroin[E]
- Marijuana[N]
- Crack[M]

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

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

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

Drug related to the second most serious consequences:
- Heroin[L,E]
- Marijuana[N]
- Pills (benzodiazepines, antidepressants, phenobarbital)[M]

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

New or emerging problems:
- Methamphetamine[L]
- Diverted prescription drugs[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

The heroin problem appears relatively stable between spring and fall 2002 with a few exceptions:

- South American (SA) heroin remains the most available form, but it has become easier to purchase Southeast Asian (SEA) and Southwest Asian (SWA) heroin.[L]
- The percentage of primary heroin users has increased slightly (to about 10 percent of the clients in one treatment program).[N]
- Most patients are self-referred, but criminal justice referrals to treatment continue to increase.[M]

COCAINE

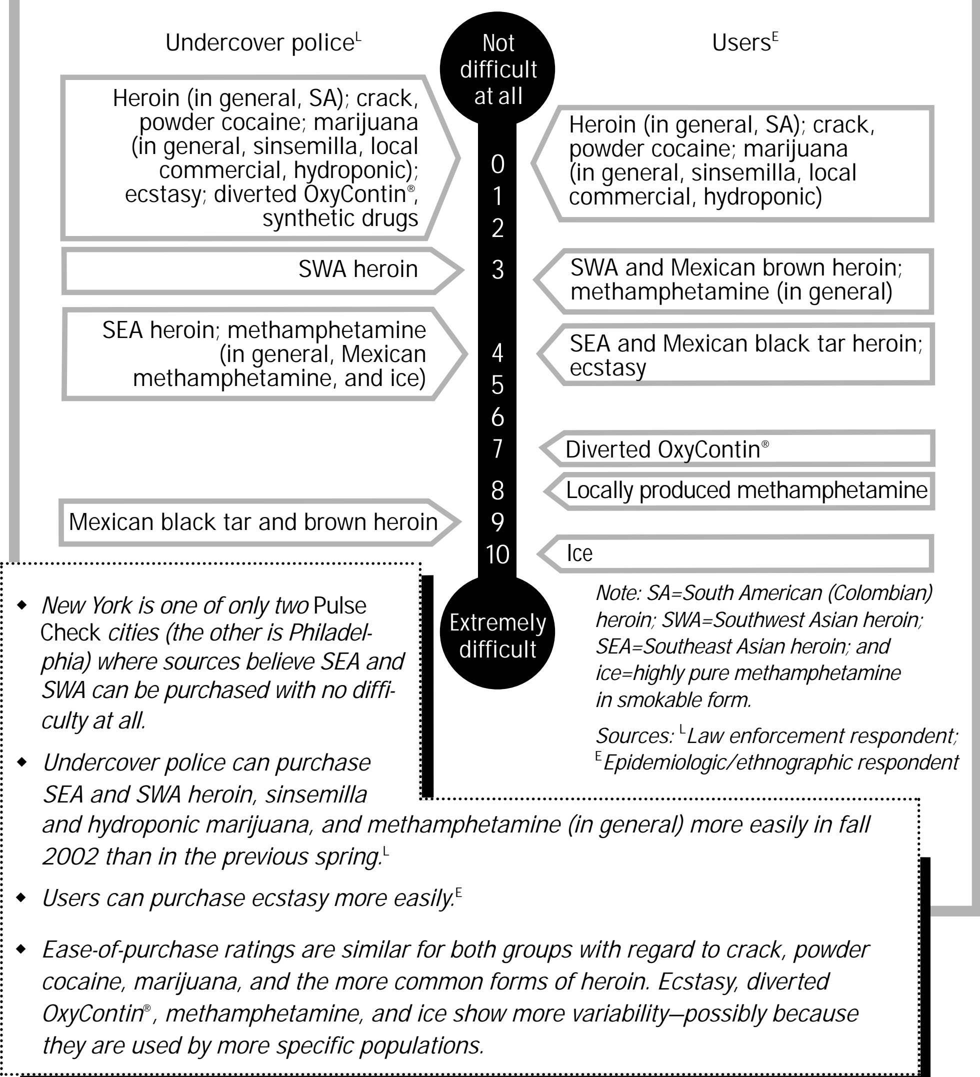
Between spring and fall 2002, the powder and crack cocaine problems appear stable.

- Crack remains the drug associated with the most serious consequences in the city.[L,E,N,M]
- Two sources consider crack the city's most widely abused drug.[L,N]

MARIJUANA

Between spring and fall 2002, three shifts are reported:

- The number of high school- and college-age users is increasing.[E]
- Sinsemilla and hydroponic marijuana have become even easier to purchase than before.[L]
- Grow operations have become more sophisticated over the last few years, with more information available on the Internet.[L]



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

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

- *New York is one of only two* Pulse Check *cities (the other is Philadelphia) where sources believe SEA and SWA can be purchased with no difficulty at all.*
- *Undercover police can purchase SEA and SWA heroin, sinsemilla and hydroponic marijuana, and methamphetamine (in general) more easily in fall 2002 than in the previous spring.[L]*
- *Users can purchase ecstasy more easily.[E]*
- *Ease-of-purchase ratings are similar for both groups with regard to crack, powder cocaine, marijuana, and the more common forms of heroin. Ecstasy, diverted OxyContin®, methamphetamine, and ice show more variability—possibly because they are used by more specific populations.*

METHAMPHETAMINE

Although the numbers are still low, between spring and fall 2002 five minor developments are reported:

- Undercover police find it easier to purchase methamphetamine.[L]
- Methamphetamine use continues to increase in the gay community.[E] The drug is increasingly mentioned in anecdotal emergency department reports about that population—a population that is often a bellwether, as in the case of ketamine and ecstasy.[L]
- Some adolescents are snorting methamphetamine in one Bronx neighborhood, where it is known as "bling bling."[E]
- Mexican methamphetamine users are increasingly using a Manhattan needle exchange.[E]
- For the first time, a few small meth labs have been noted in The Bronx and on Long Island. However, the drug is still less available than other drugs. Most seizures are Mexican ice from California, found in clubs, in both pill and powder form.[L]

MDMA (ECSTASY)

As recently as 5 years ago, ecstasy was considered an emerging problem. It now appears endemic, as suggested by the following reports:

- Ecstasy is making its inital appearance in the treatment population, according to anecdotal information.[M]
- While users are predominantly White, the number of Black and Hispanic users is increasing, particularly addicts who spike heroin with ecstasy.[E]
- Ecstasy shavings are included in heroin bags as marketing innovations ("on the ball" or "moon stone").[E]
- People are starting to change their perception of ecstasy: they no longer regard it as harmless.[L]
- Users are finding it easier to purchase ecstasy, compared with the previous reporting period.[E] Undercover police, however, are finding no change in ease of purchase.[L]
- "A tidal wave" of million-pill shipments has been coming in from Belgium, the Netherlands, Luxemburg, and Germany.[L]

OTHER DRUGS

- Diverted OxyContin® (oxycodone hydrochloride controlled-release): The numbers have increased slightly but are still small.[M]
- Synthetic drugs: Together with ecstasy, these drugs—including ketamine, phencyclidine (PCP), lysergic acid diethylamide (LSD), gamma hydroxybutyrate (GHB), and flunitrazepam (Rohypnol)—remain the second most widely abused in the city. Since the last reporting period, undercover police have found them easier to purchase.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment respondent, whose 1,070-bed facility operates at nearly full capacity, reports crack cocaine as the primary drug of abuse among three-quarters of that program's clients *(see pie chart on the first page of this chapter)*. Treatment percentages appear relatively stable between spring and fall 2002, except for a slight increase in heroin as a primary drug of abuse.[N]
- The methadone treatment respondent is with a facility that includes two methadone, one outpatient, and three residential programs. With a combined monthly capacity of 1,300, the facility operates at nearly full capacity.
- Methadone maintenance treatment is available throughout the metropolitan area. Public and private methadone treatment availability remained stable between early and late 2002.[E]
- Treatment providers are addressing issues they didn't have to years ago. More people are presenting with mental health issues due to increased trauma in their lives, such as lifelong sexual abuse (both men and women).[N]
- Increases in patients presenting with post-traumatic stress disorder (PTSD), mood disorders, and psychosis might be attributed to non-drug-related external events and changes in the environment—for example, September 11, changes in Medicaid, and growing unemployment due to the slowing economy. These increases might also be partly due to the traumatizing course of addiction and its associated lifestyle, and they may partially be an artifact of increased staff awareness of mental health issues.[M]
- Staff trained to treat co-occurring psychiatric and substance abuse disorders are becoming scarcer.[M]
- Both treatment sources believe the situation over the past decade has been complicated by increased court referrals and by lack of housing opportunities for recovering clients.
- The non-methadone treatment source believes that lack of jobs (but not training opportunities) for recovering clients has somewhat exacerbated the situation over the past decade.
- The methadone treatment source believes the situation has been moderately complicated over the past 10 years by the declining cost of drugs (particularly high-purity heroin) and by the advent of hepatitis C (with 75 percent of needle users testing positive).
- Both treatment sources believe that caseloads have remained relatively stable over time. Staffing levels, however, have declined, and individual cases have become more complex.

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. For example, all methadone clients are primary opiate users who may use drugs other than opiates in a secondary or tertiary manner.

- *The epidemiologic and both treatment sources agree that heroin users are predominantly older (>30 years) central-city Hispanic males.*
- *Young (18–30) suburban Hispanics are emerging as a user group.*[E]
- *Methadone treatment clients tend to be self-referrals, while non-methadone clients tend to enter treatment via the criminal justice system.*
- *User characteristics appear stable between spring and fall 2002.*[E,N,M]

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	38	32.5	35
Gender	70–75% male	67% male	65% male
Race/ethnicity	Hispanic	White, Hispanic	Hispanic
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high	Junior high
Employment at intake	N/A	Unemployed	Unemployed

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

- *Methadone treatment clients tend to inject heroin, unlike the other two study populations, who tend to snort or smoke the drug.*
- *Use patterns appear stable between spring and fall 2002 with one exception: the emerging group of young suburban heroin users continues to shift from snorting to injecting drug use.*[E]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Snorting	Smoking	Injecting
Other drugs taken	Powder cocaine (speedball); crack	Crack ("chasing the dragon"); alcohol	Other opiates; powder cocaine (speedball); crack; pills (benzodiazepines, anti-depressants, phenobarbital)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone	In groups/ among friends	Alone

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

- *Cocaine users tend to be older males from low socioeconomic backgrounds who are unemployed and have little education.*[E,N,M]
- *Cocaine users in the non-methadone program tend to be Black, while those in the methadone program tend to be Hispanic.*[N,M]
- *User characteristics appear stable between spring and fall 2002.*[E,N,M]

Who's most likely to use cocaine?

	Crack			Powder cocaine		
Characteristic	E	N	M	E	N	M
Age group (years)	>30	18–30	>30	>30	>30	NR
Mean age (years)	36	27	NR	35	NR	NR
Gender	>50% male	70% male	NR	>50% male	>50% male	65% male
Race/ethnicity	Black Hispanic	Black	Hispanic	Black Hispanic	Black	Hispanic
Socioeconomic status	Low	Low	Low	Low	Low	Low
Residence	Central city	Central city	Central city	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Individual	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high	Junior high	N/A	Junior high	Junior high
Employment at intake	N/A	Unemployed	Unemployed	N/A	Unemployed	Unemployed

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

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	18–30	18–30	NR
Gender	>50% male	80% male	65% male
Race/ethnicity	Black	Black, Hispanic	Hispanic
Socioeconomic status	Low, middle	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	Unemployed	Unemployed

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

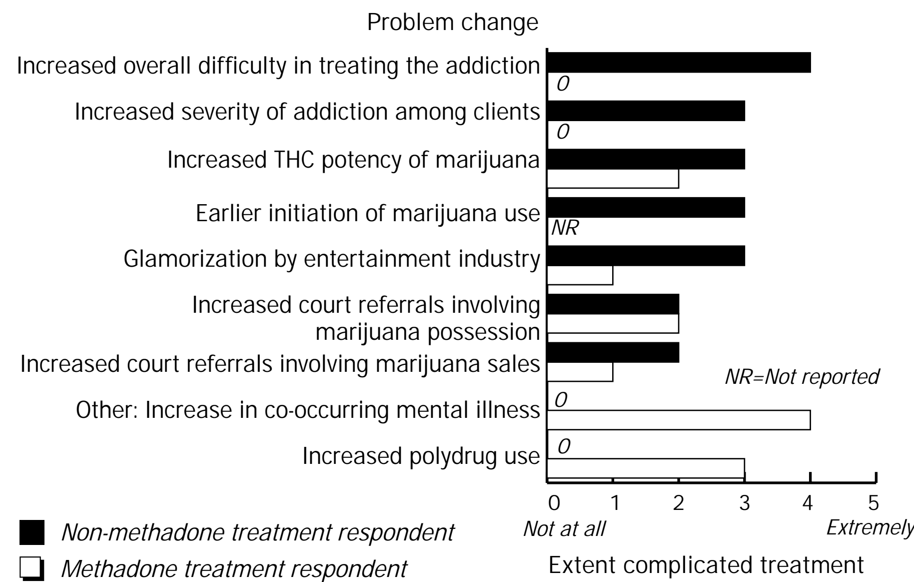
- *Marijuana users tend to be young adult males, primarily Black or Hispanic.*[E,N,M]
- *Marijuana users in the methadone program tend to have more education than those in the non-methadone program.*[N,M]
- *User characteristics appear relatively stable between spring and fall 2002.* [E,N,M]

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

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



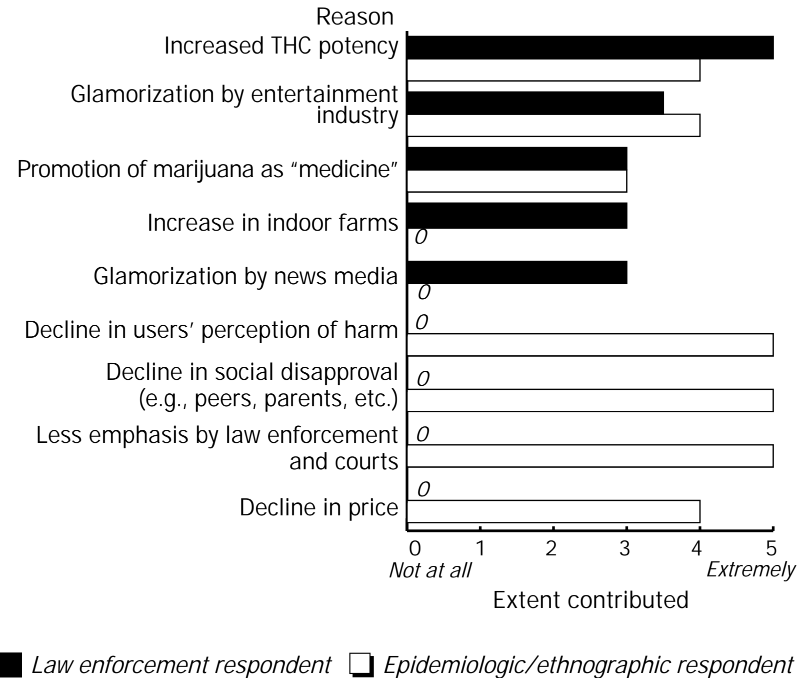
What they have to say...

- *Perception of harm: Neither treatment source believes that user perception of harm has declined over the past decade. Users' "never thought it was harmful," even 10 years ago.*[N] *"The perception has gone the other way."*[M]
- *Entertainment industry: Rap music videos portray teens smoking blunts while drinking alcohol.*[N]

What they have to say...

- *Price: As in the vast majority of* Pulse Check *cities, sources agree that price has not declined.*[L,E] *But price ranges are more varied, with lower prices contributing to use by adolescents.*[E]
- *Indoor farms: High-quality hydroponic marijuana, much of it grown indoors, has increased over the last 3 years. And indoor growing makes interdiction more difficult.*[L]
- *Perception of harm: Both sources agree that users do not perceive marijuana as harmful. The law enforcement source, however, believes that users had that same misperception 10 years ago. The epidemiologic source believes the promotion of marijuana as "medicine" contributes to the misconception that it's harmless.*[E]
- *Social disapproval: The epidemiologic source notes a decline in social disapproval, especially among pre-teens. The law enforcement source believes social disapproval was lacking even 10 years ago and efforts to change perceptions have been largely ineffective.*

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



WHO'S MOST LIKELY TO USE METHAMPHETAMINE?

Users tend to be sellers, generally from one of these groups:

- The gay community
- Motorcycle gangs
- Lower income groups
- Persons attending discos or raves

WHO'S MOST LIKELY TO USE ECSTASY?

- Users are predominantly White middle-class young adults (18–30 years). However, the number of Black and Hispanic users is increasing, particularly addicts who spike heroin with ecstasy.[E]
- Ecstasy is making its initial appearance in the treatment population, according to anecdotal information.[M]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, crack cocaine, powder cocaine, marijuana, and ecstasy are sold virtually everywhere, including the following:[L,E]

- Streets/open-air markets
- Crack houses/shooting galleries
- Private residences
- Public housing developments
- College campuses
- Nightclubs and bars
- Shopping malls
- The Internet
- Playgrounds/parks
- Private parties
- Concerts
- Around supermarkets
- Hotels and motels
- Inside cars

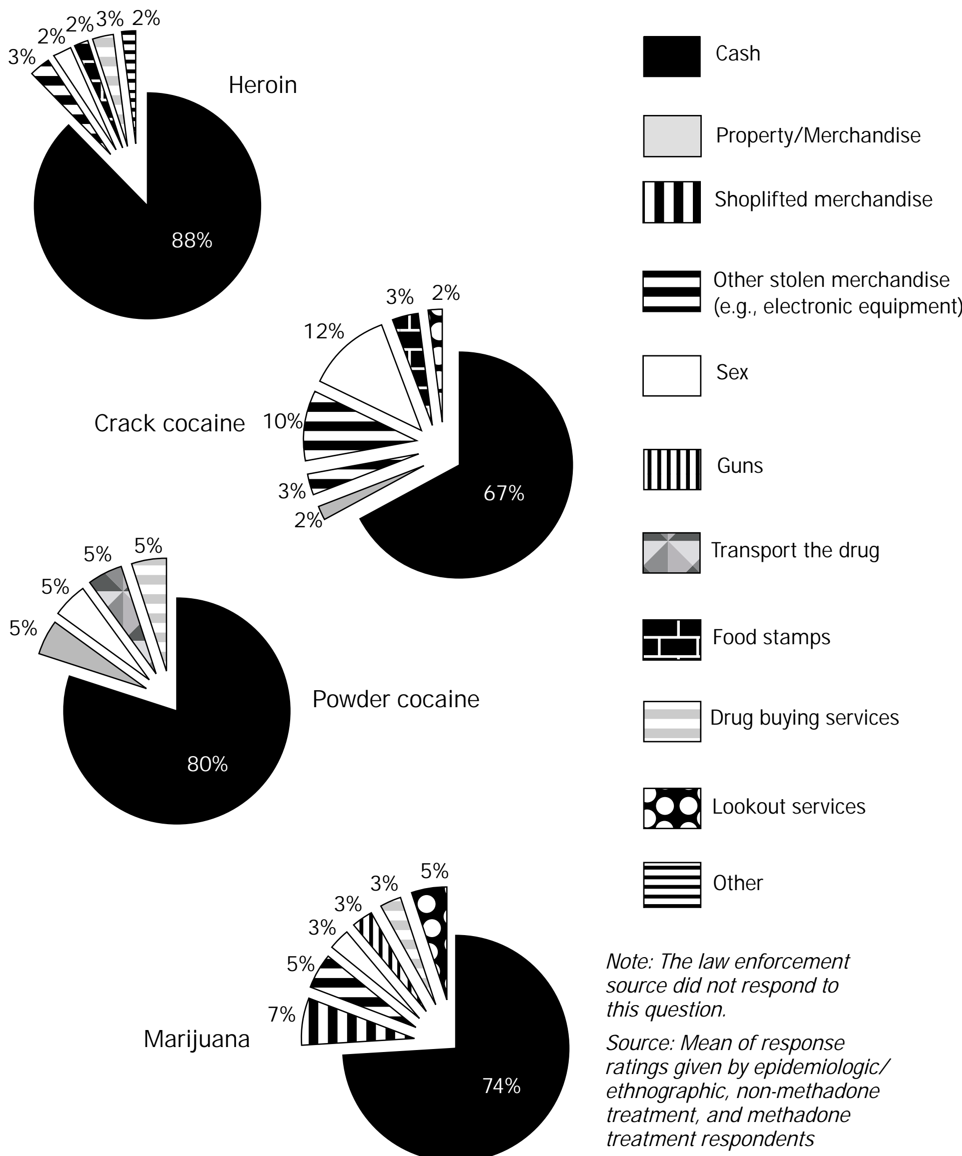
Except for crack, all of those drugs are also sold at raves and around drug treatment clinics. Additionally, marijuana and ecstasy are available in schools (elementary, junior high, or high schools). Methamphetamine sales venues are limited to private residences, nightclubs and bars, and raves.

The majority of these sales venues also serve as use settings.

HOW DO DRUGS GET FROM SELLER TO BUYER?

- Heroin, crack cocaine, or powder cocaine can be purchased in several ways, including the following:[L,E]
  1. The buyer drives down a block well known for drug sales.
  2. One person asks what the buyer wants.
  3. Another person gets the drug from the supplier.
  4. A third person brings the drug to the buyer.
  5. Any step in this series can involve cell phones, pay phones, runners, or hand signals.
- Marijuana sales are more socially based than other drug sales, with sellers approaching and soliciting potential buyers in a wide range of social settings.
- To purchase ecstasy and other designer drugs—such as GHB, gamma butyrolactone (GBL), flunitrazepam, steroids, or ketamine—buyers are more likely to go to a nightclub, a campus, some other partygoing venue, or the Internet.
- As shown below, the majority of these transactions involve cash. A variety of other commodities, however, are often exchanged—particularly in the case of crack.

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



Note: The law enforcement source did not respond to this question.

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

What they have to say...

- *Drug transactions have increasingly become "cash only" over the past 10 years. The larger organizations of the past sometimes sold drugs on consignment. But today's smaller, more independent, street-level dealers can't recoup any outlay quickly enough to do so.*[E]
- *Heroin, in particular, is involved in cash-only transactions—more so than in the majority of other* Pulse Check *cities.*
- *During the peak of the crack epidemic, transactions were more diversified, with sex and bartered stolen goods often accepted in lieu of cash. Now one source estimates that about 80 percent of crack sales involve cash.*[M]
- *Sex is involved in as much as 25 percent of crack transactions among this treatment population.*[N]
- *Shoplifting is involved in up to one-fourth of powder cocaine transactions and 20 percent of marijuana transactions: the shoplifted items are often sold, and the cash proceeds are used to buy the drugs.*[N]

WHO'S SELLING HEROIN?[L]

At the trafficking level:

- SA heroin: Colombian, Mexican, and Dominican groups
- SWA: Afghani, Pakistani, Indian, Russian, and West African groups
- SEA: Chinese (Fukinese Province) groups

At the street level:

- Sellers vary by neighborhood.
- Some are organized; some are independent.
- Many recent immigrants are manipulated into selling.

WHO'S SELLING COCAINE?[L]

Crack cocaine:

- Sellers tend to be Black and Hispanic—more so than distributors of other drugs.
- Some are organized; some are independent.

Powder cocaine:

- Sellers tend to be Colombian, Mexican, and Dominican groups.
- Some are organized; some are independent.

WHO'S SELLING MARIJUANA?[L]

- Some are organized; some are independent.
- Organized crime is sometimes involved.

How much does marijuana cost?

Form	Unit	Price
"Normal"	One bag 1 oz 1 lb	$10[E] $100–$200[L] $1,000–$2,000[L]
"Hydro"	One bag 1 oz 1 lb	$20[E] $300–$1,200[L] $3,000–$5,000[L]

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

All reported prices are stable between spring and fall 2002.

Which drug sellers are associated with which crimes?

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

Source: Law enforcement respondent

While marijuana is not generally associated with prostitution or violence, it is associated with gang-related activity and nonviolent criminal acts.

How much does heroin cost?

Form[a]	Unit	Price
SA	One bag One bundle (10 bags) 1 g 1 oz 1 kg[b]	$10–$14[L] $75–$100[L] $60–$80[L] $2,000[L] $60,000–$75,000[L]
SWA	1 g 1 oz 1 kg	$25–$45[L] $1,000–$1,500[L] $60,000–$100,000[L]
SEA	700 g	$40,000–$80,000[L]
Unspecified	0.1 g packet[c] 1 g bundled	$10[E] $80–$100[E]

[a]SA=South American (Colombian); SWA=Southwest Asian; SEA=Southeast Asian
[b]Purity 85–96%; [c]Purity >60%
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	One vial One bag 1 g Eightball 1 oz	$10–$20[L] $10 and $20[E] $25–$45[L] $175[L] $1,000–$1,500[L]
Powder	bag 1 g Eightball 1 oz 1 kg	$20–$25[L] $25–$50[E] $25–$35[L] $120–$150[L] $600–$2,000[L] $22,000–$24,000[L]

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

Between spring and fall 2002:

- *Crack dealers may be trying to sell larger quantities at higher prices to reduce the number of transactions and thereby lower the likelihood of being arrested.[E]*
- *All other reported prices are stable.*

How much does methamphetamine cost?

Unit	Price
1 pill	$10–$20[L]
One bag	$20[E]
1 g	$100–$300[L]
1 oz	$1,600–$6,000[L]

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

All reported prices are stable between spring and fall 2002.

How much do various other drugs cost?

Drug	Unit	Price
Diverted OxyContin®	NR	$15–$30[L]
Ketamine	10 mL	$22–$100[L]
Ketamine hydrochloride	1 g	$40–$50[L]
PCP	1 oz	$300–$400[L]

Sources: [L]*Law enforcement respondent*

All reported prices are stable between spring and fall 2002.

WHO'S SELLING ECSTASY?

The law enforcement source reports:

- Ecstasy sellers tend to be younger than those who sell other drugs.

How much does ecstasy cost?

Unit	Price
Pill (wholesale)	$1.50–$13[L]
Pill (street)	$12–$25[E]
Pill (retail)	$20–$28[L]
Pill (clubs)	$25–$35[E]

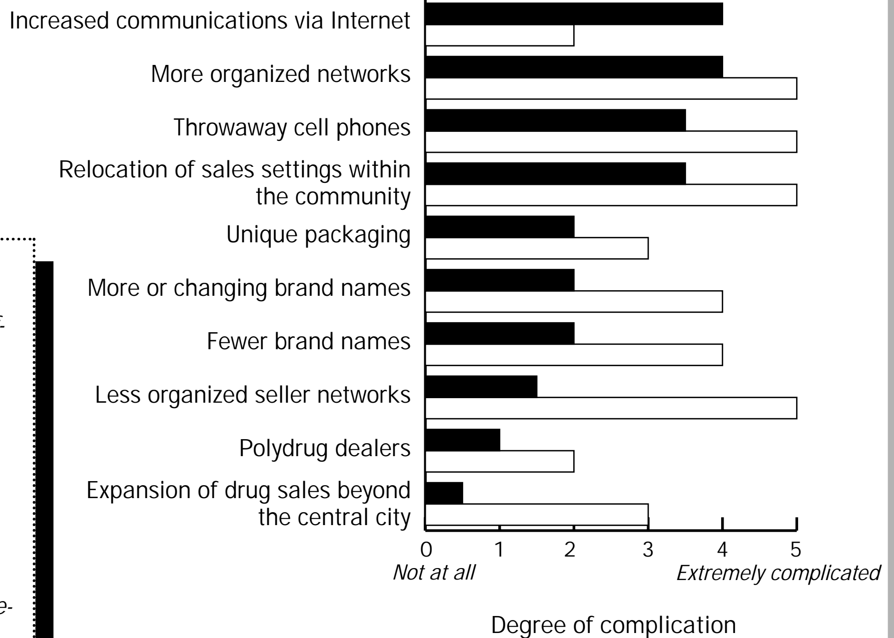
Sources: [L]*Law enforcement respondent;* [E]*Epidemiologic/ethnographic respondent*

All reported prices are stable between spring and fall 2002.

- "Everyone wants to get involved" because of the high profit margin: pills bought in bulk cost $0.50 each; at the next level, they sell for $5 each; in clubs, they sell for $25 each. Thus, a $50,000 purchase can make $2 million in profit.
- The primary trafficking groups are Israeli, followed, in descending order of magnitude, by Dominican, Colombian, Chinese, Eastern European, and Vietnamese groups.

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 New York?



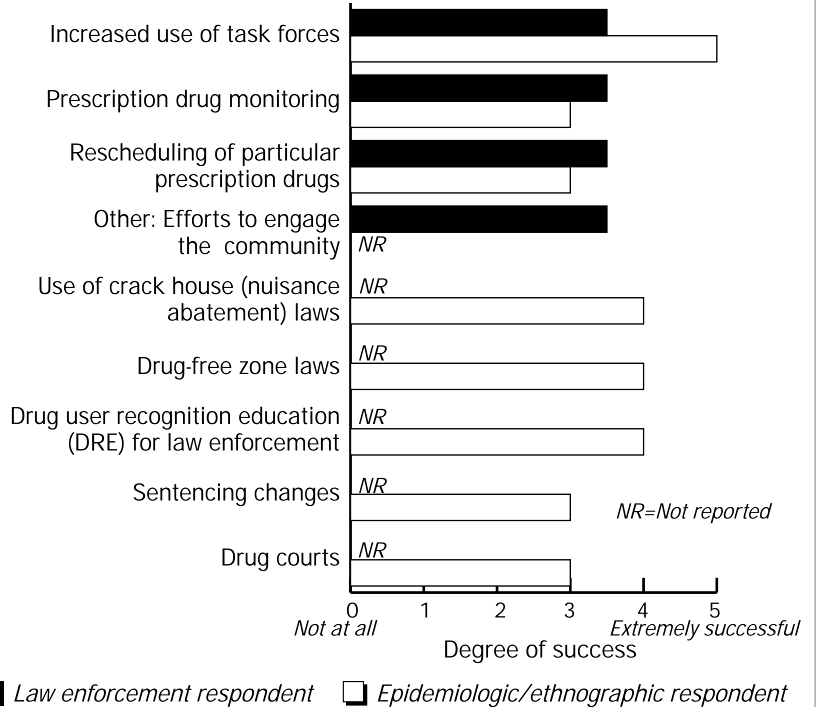
Law enforcement respondent
Epidemiologic/ethnographic respondent

What they have to say...

- *The Internet is still new for law enforcement: traffickers are still one step ahead. As law enforcers become better trained in the use of the Internet for drug sales, the knowledge gap is expected to close.*[L]
- *Lessening of organization within some networks makes it easier to disrupt them.*[L]
- *Unique packaging makes it easier for law enforcement to identify dealers.*[L]
- *Relocation of sales settings within the community can complicate disruption efforts, particularly when they move indoors.*[L]

What they have to say...

- *Task forces: New York has a particularly high level of task force cooperation compared to the rest of the country. For example, at least 15 units of police and agents are working together or with the areas's High Intensity Drug Trafficking Area (HIDTA). Also, Mobile Enforcement Teams (MET) are groups of special agents who go to communities for a few months to address a specific problem.*[L]
- *Prescription drug monitoring: The Drug Enforcement Administration (DEA) Diversion Unit targets diversion from pharmacies, hospitals, and doctors. It offers training opportunities, such as a special school, refresher courses, and symposia.*[L]
- *Community engagement: Law enforcement engages the community by educating the public, providing information, and answering questions via conferences, press releases, public forums, college meetings, and the Internet.*[L]



FOLLOWUP: THE SEPTEMBER 11 ATTACKS AND THEIR AFTERMATH—ANY CONTINUING EFFECTS ON THE DRUG ABUSE PROBLEM?

Not surprisingly, New York shows more continuing effects than any other *Pulse Check* site, particularly in the following areas:

- Changing trafficking patterns: Overall, September 11 did not have a major impact on drug trafficking. However, informants report that some traffickers are afraid to fly directly to JFK Airport, so they go to other cities and use rail, bus, car, and other means of transportation. Some traffickers have broken down shipments, making them smaller, so interdiction doesn't stop all traffic.[L]
- Southwest Asian heroin trends: Even before September 11, prices were dropping, purity was rising, and more groups were becoming involved in heroin sales. September 11 accelerated the process by disrupting normal patterns. Traffickers—Russians, West Africans, and a possible new French connection—became desperate to get rid of heroin already in the pipeline.[L]
- Price and availability: Price and availability of many drugs spiked immediately after September 11 but returned to normal soon thereafter and have remained relatively stable since then, except for increased variability in the price of cocaine bags. This variability might indicate that people are less afraid of the newer security measures, believing that the measures are aimed at terrorism, not illegal drugs.[E]
- Drug use: Chronic drug users are accustomed to hustling more than other people, adapting to catastrophes every day. When interviewed, however, some users mentioned using more drugs because of increased stress. (The epidemiologic source is leading a team that will conduct a followup survey to obtain more information on the degree of stress-related increases in drug use after September 11).[E] No rise in drug use is noted among clients in the non-methadone treatment program.[N]
- Mental health issues: Clients at this program, whose offices are located five blocks from Ground Zero and which continued operating throughout the day of the attacks, exhibited exacerbated incidence of depression, PTSD, and substance abuse. These findings are similar to those in a NIDA-funded survey (see *NIDA Notes*, Volume 17, Number 4, November 2002), which showed that residents living closest to the World Trade Center were most likely to suffer those symptoms.[M]