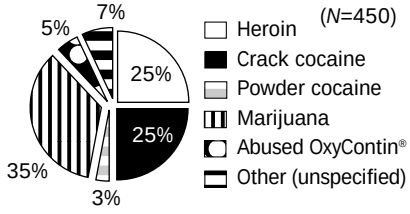
PHILADELPHIA PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 5,100,931
- Median Age: . . . . . 36.4 years
- Race (alone):
  - White: 72.1%
  - Black: 20.1%
  - American Indian/ Alaska Native: 0.2%
  - Asian/Pacific Islander: 3.4%
  - Other race: 2.5%
  - Two or more races: 1.6%
- Hispanic (of any race): 5.1%
- Unemployment rate: 6.2%
- Median household income: $47,536
- Families below poverty level with children <18 years: 14.4%

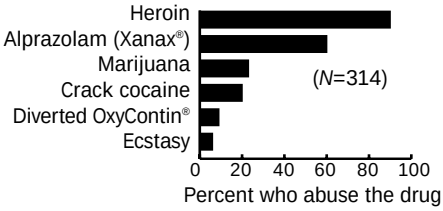
*Source: U.S. Census 2000**

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 primary, secondary, and tertiary use

Source: Methadone treatment respondent

Between spring and fall 2002:

- *Treatment percentages rose slightly for heroin, crack cocaine, and diverted OxyContin® as primary drugs of abuse in the non-methadone program.*[N]
- *The number of clients abusing marijuana increased in the methadone program, possibly because the program began testing clients for marijuana.*[M]

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

All four *Pulse Check* respondents state that Philadelphia's drug problem remained stable with respect to the abuse of heroin, crack cocaine and marijuana. Three of the four sources consider the current drug problem to be very serious, and the fourth considers it somewhat serious.

Positive developments are noted with respect to the drug market:

- Operation Safe Streets has successfully shut down hundreds of outdoor drug markets, making it more difficult to purchase heroin, crack and powder cocaine, and marijuana.[E]
- Diverted OxyContin® (oxycodone hydrochloride controlled-release) is also more difficult to purchase on the street. Law enforcement action has made a difference, with large diversion cases, such as the arrest and conviction of a significant dealer in the city.[L,E]
- Drug-related incarcerations have increased due to law enforcement efforts.[N]

Some increases are noted among users:

- Emergency department (ED) mentions involving diverted OxyContin®, heroin,[E] marijuana,[E] and phencyclidine (PCP)[L] increased. Mortality involving OxyContin® increased as well.[E]
- The number of marijuana users increased among first-time methadone clients, who are entering treatment at increasingly younger ages.[M]

Opinions vary about which drug is the most widely abused in Philadelphia due to the different perspective each respondent brings. Three of the four sources agree that heroin abuse is responsible for the most serious drug-related consequences, similar to reports by 42 sources in 22 *Pulse Check* cities.[L,E,M] Finally, several drug problems are emerging: PCP, methylenedioxymethamphetamine (MDMA or ecstasy), and diverted OxyContin®.

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

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

Second most widely abused drug:
- Heroin[L,N]
- Crack[L,E]
- Crack and benzodiazepines[M]

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

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

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

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

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

New or emerging problems:
- PCP[L,E]
- Ecstasy[E,M]
- Diverted OxyContin®[E,M]

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

**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

According to three of the four Pulse Check *respondents, heroin remains the drug associated with the most serious consequences.*[L,E,M]

- Between spring and fall 2002, the number of primary heroin users increased slightly in the overall and new treatment population.[N]
- The number of hospital emergency department mentions of heroin increased significantly.[E]
- The number of female heroin users increased.[E]

COCAINE

Overall, the cocaine problem remains stable at high levels.[N]

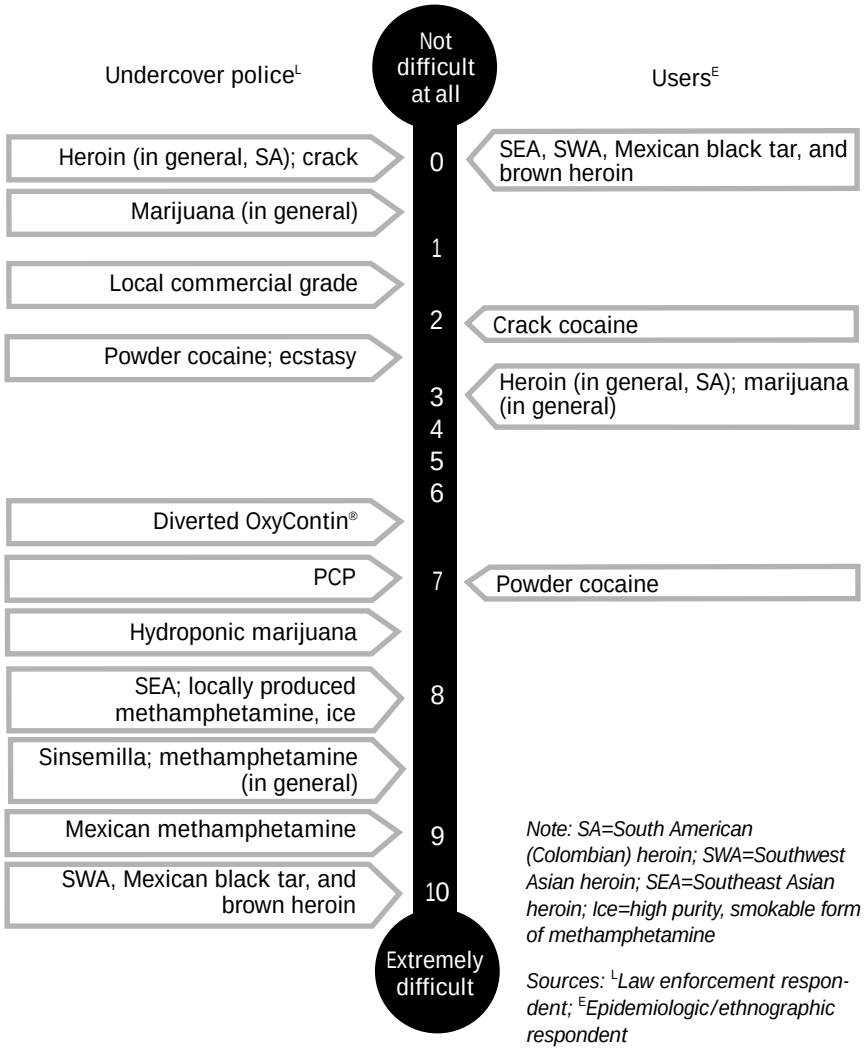
- Among non-methadone treatment clients, crack cocaine remains the most common primary drug of abuse.[N]
- The percentage of crack users in both the overall and first-time treatment populations increased slightly.[N]
- Powder cocaine users are increasingly snorting, rather than injecting, the drug.[E]

MARIJUANA

Marijuana use remains generally stable between fall and spring 2002, with two exceptions:

- The number of new users increased slightly, and these new users are younger than before.[M]
- One respondent reports a decrease in female marijuana users. This is likely due to a higher percentage of first offenders in treatment, who tend to be male.[E]

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=high purity, smokable form of methamphetamine

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

- *During this reporting period, it became more difficult to purchase heroin in the city. This may be attributable to a historical pattern of increased law enforcement crackdowns during the days leading up to Election Day in November.*[E]
- *South American (SA) remains the most available heroin form, and it remains difficult for undercover officers to purchase other forms.*[L]
- *Southwest and Southeast Asian heroin are not difficult at all for users to buy, as reported by sources in only one other* Pulse Check *city (New York).*
- *It is slightly more difficult for users to purchase sinsemilla and both forms of cocaine than during the previous 6 months.*[E]

METHAMPHETAMINE

The methamphetamine problem remains stable at low levels.

- The number of clients entering treatment for primary methamphetamine use remains low.[N,M]
- It remains difficult to purchase methamphetamine in the open-air market. Price remains stable.[L,E]
- Methamphetamine continues to be produced primarily in "box labs" run by large, independent operations, generally using the quick-cooking ("Nazi") method and the P2P method.[L]

MDMA (ECSTASY)

Ecstasy indicators are mixed for the reporting period.

- The number of treatment clients reporting ecstasy use increased slightly.[M]
- Fewer females are using ecstasy.[E] This change leaves a fairly equal number of male and female users.[E,N]
- A new name has appeared in the city for the drug: "boogie."[M]
- The practice of "candy flipping" (taking ecstasy in combination with PCP) continues.[E]

OTHER DRUGS

- Clients abusing OxyContin® increased among the overall treatment population and those entering treatment for the first time.[N]
- Since its resurgence in spring 2002, PCP use continues to increase in the Philadelphia area. Hospital ED admissions for PCP use have been increasing, particularly among teens.[E]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The reporting non-methadone treatment facility serves 450 clients and is operating at full capacity. Among these clients, the primary drug of abuse is marijuana, followed closely by heroin and crack cocaine (*see pie chart on the first page of this chapter*). Treatment percentages for heroin, crack cocaine, and OxyContin® as the primary drugs of abuse increased slightly between spring and fall 2002.[N]
- The reporting methadone treatment facility is capable of treating 340 clients. Current enrollment is 314.[M] Despite the availability of treatment slots, there is a 3- to 4-week waiting period due to current understaffing.
- The most significant barriers to treatment are limited slot capacity[M] and paperwork.[N] "In the typical work week, 25 of 45 hours are spent on paperwork for managed care, the State, the joint commission, or the county."[N]
- An increase in the incidence of hepatitis C among clients may be attributable to increased diagnoses rather than to an increased number of clients with the virus. A recent hepatitis C problem within the city's fire department led to increased community awareness and, therefore, increased testing.[N]
- More treatment clients are presenting with antisocial disorders, psychosis, mood disorders, and aggressive behavior. This may be due to the increased number of clients transitioning from incarceration, during which their disorders or symptoms were exacerbated.[N] Another cause may be the lack of resources available to low-income individuals for treatment of mental health problems.[N]
- Lack of transportation no longer is a barrier to clients in some programs, because recovery houses throughout the city have their own vans. Many treatment agencies help fund these services. Programs also provide bus tokens to clients not coming from recovery houses.[N] On the other hand, the methadone treatment respondent cites a lack of transportation as an increased problem among clients who are no longer eligible for welfare assistance.[M]
- The number of clients with HIV/AIDS increased slightly, possibly due to an increase in high-risk behaviors (unprotected sex and needle sharing) among younger clients.[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 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.

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	18–30	18–30	18–30; >30
Mean age (years)	29	26	48
Gender	67% male	60% male	55% male
Race/ethnicity	White	Black	White
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Recovery houses	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

Heroin users in the methadone versus non-methadone treatment programs differ notably:

- *Primary heroin users in the non-methadone program are more likely to be in their midtwenties and Black, while methadone treatment clients are more likely to be in their forties and White.*[N,M]
- *As is the case in most* Pulse Check *cities, patients in methadone programs are generally self-referred, while those in non-methadone programs usually come from recovery houses in the city.*[N,M]
- *While most methadone treatment clients are self-referred, an increasing number are coming from drug courts.*[M]

Use patterns changed in several ways between spring and fall 2002:

- *Among new users in the methadone treatment program, approximately 80 percent now snort heroin, as opposed to the overall treatment population, who tend to inject.*[M]
- *More heroin abusers enrolled in the methadone treatment programs are abusing OxyContin® as a substitute for heroin when it is available.*[M]
- *The practice of speedballing (combining heroin and powder cocaine) appears to have decreased significantly.*[E]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball); crack	Crack or powder cocaine (speedball)	Diverted alprazolam or clonazepam (Klonopin® or "Zs"); powder or crack cocaine (speedball); diverted OxyContin®
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups/ among friends	In groups/ among friends	Alone

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

Who's most likely to use cocaine?

Characteristic	Crack			Powder cocaine	
	E	N	M	E	N
Age group (years)	>30	18–30	18–30; >30	18–30	18–30
Mean age (years)	35	26	48	26	NR
Gender	61% male	60% male	55% male	Split evenly	>60% male
Race/ethnicity	Black	Black	White	White	Black
Socioeconomic status	Low	Low	Low	Low	Low
Residence	Central city	Central city	Central city	Central city	Central city
Referral source	N/A	Recovery houses	Individual	N/A	Recovery houses
Level of education completed	N/A	Junior high	Junior high	N/A	Junior high
Employment at intake	N/A	Unemployed	Unemployed	N/A	Unemployed

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

- *The number of female crack and powder cocaine users is increasing.*[E]
- *Between spring and fall 2002, the highest education level completed declined from high school to junior high for crack and powder cocaine users.*[N]
- *While methadone clients are predominantly self-referred, an increasing number come from drug courts.*[M]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	18–30	18–30	>30
Mean age (years)	29	26	37
Gender	78% male	60% male	NR
Race/ethnicity	Black	Black	White and Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Recovery houses	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.

- *Marijuana appears to be used more in groups and among friends, rather than alone as reported in the last* Pulse Check.[N]
- *Marijuana users in treatment reported lower levels of education than the same user group the last reporting period.*[N]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

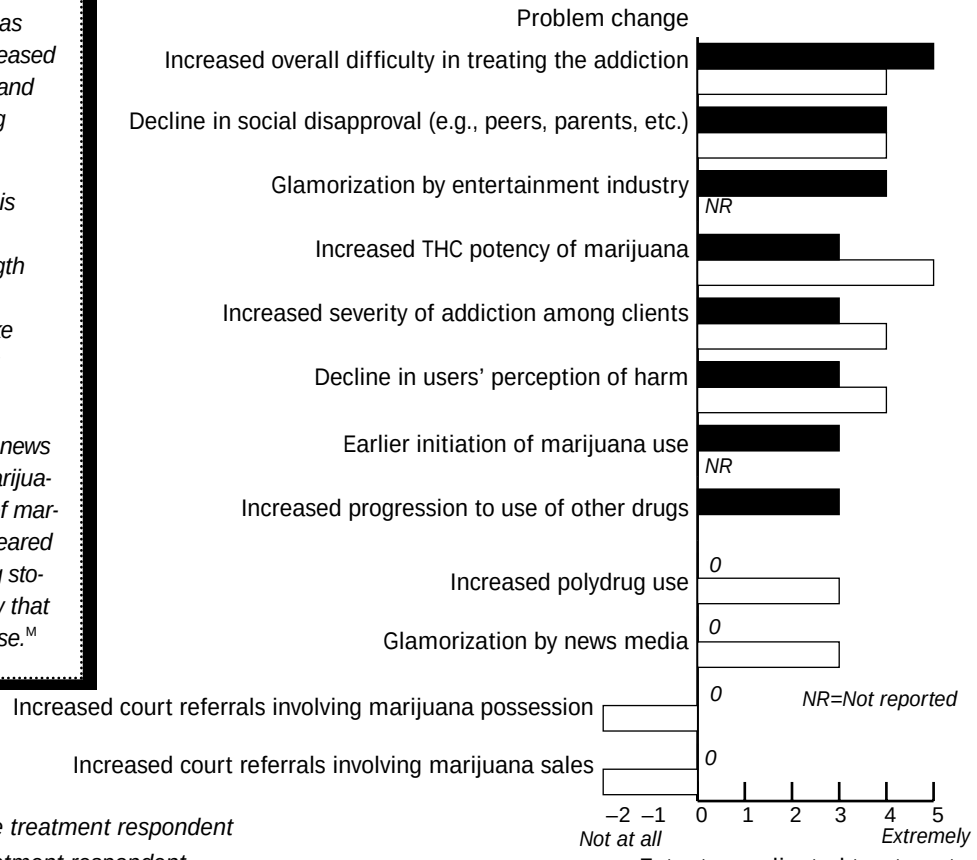
Respondents associate marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:[N,M]

- Drug-related arrests
- Automobile accidents
- Chronic obstructive pulmonary disorder (COPD)
- Short-term memory loss
- Deteriorating family or social relationships
- Poor academic performance
- Dropping out of school
- Unemployment

What they have to say...

- *Rather than hindering treatment efforts, as reported in a few* Pulse Check *cities, increased court referrals involving marijuana sales and possession have served to help by getting people into treatment.*[M]
- *The increased THC content of marijuana is seriously complicating treatment, both because the drug has increased in strength (two to three times stronger than in the 1970s)*[N] *and because some users mistake their THC withdrawal as an effect of their methadone treatment.*[M]
- *Both the entertainment industry and the news media have complicated treatment of marijuana: the former by glamorizing a lifestyle of marijuana use, particularly in music videos geared toward youth;*[M] *and the latter by reporting stories about marijuana legalization in a way that implies the harmlessness of marijuana use.*[M]

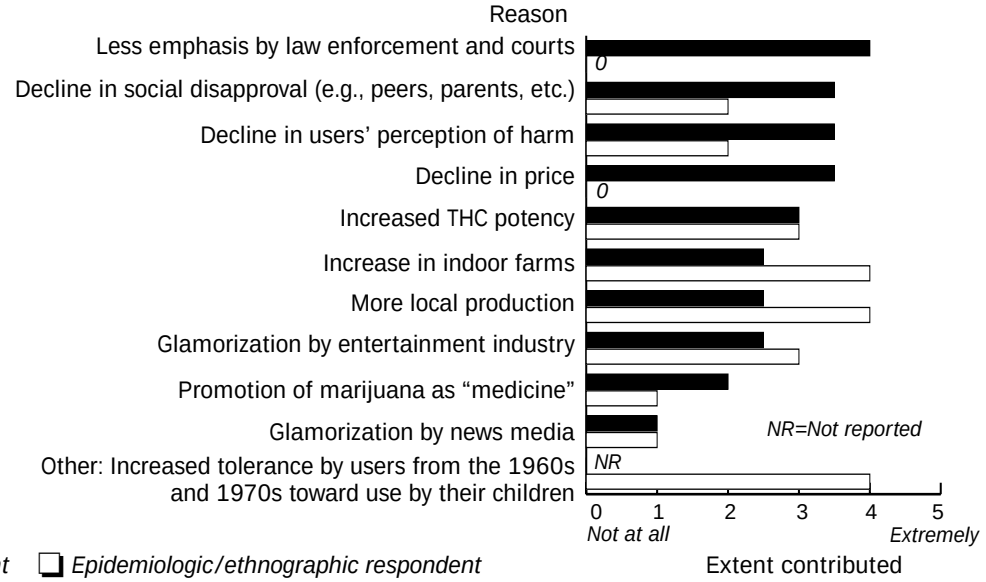
Marijuana-using clients: To what extent have changes in the following areas complicated their treatment over the past 10 years?



What they have to say...

- *Glamorization of marijuana use by the entertainment industry has significantly contributed to use of the drug, particularly among youth.*[L,E,N]
- *The fact that many youth today are the children of marijuana users from the 1960s and 1970s contributes to parents tolerating, even approving of, marijuana use by their children.*[L,N]

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

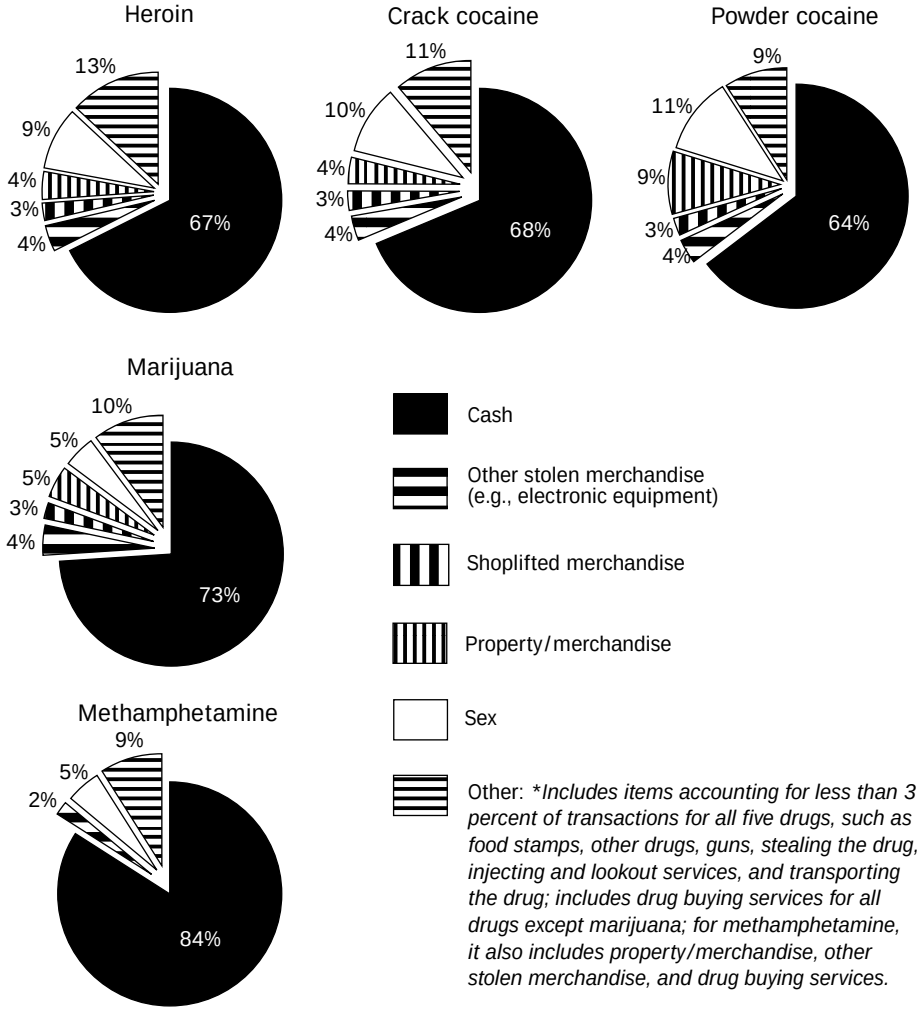


THE MARKET PERSPECTIVE

HOW DO DRUGS GET FROM SELLERS TO BUYERS?

- Heroin, crack and powder cocaine, marijuana, and methamphetamine are sold primarily through hand-to-hand transfers in vehicles or residences. In addition, there is still some open-air activity.[L,E]
- Ecstasy is sold at both the wholesale and retail levels:
  - Wholesale transactions take place via vehicle transport, parcels from mail or shipping services, or concealed in suitcases on airlines.[L]
  - Retail sales are generally related to particular venues, such as concerts or rave parties.[L]
- OxyContin® is obtained by doctor shopping and prescription fraud, and then sold illegally.[L,E]
- Gamma hydroxybutyrate (GHB) is sold through hand-to-hand transactions, as well as through the mail. Users also find recipes for the drug on the Internet and make their own supply of GHB.[L]

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...

- Over the past 10 years, the practice of sex-for-crack has declined, while exchange of property for crack has increased. Further, more stolen electronic equipment is being used as payment for drugs, particularly compact discs (CDs) and CD players.[E]
- Sex, in lieu of cash, still accounts for an estimated 11 percent of drug transactions involving crack cocaine—about the same as the average percentage estimated by other *Pulse Check* sources across the country. The extent to which sex is traded for powder cocaine, however, is somewhat higher than the *Pulse Check* average across sites.[L,E,N,M]
- As drug trafficking organizations have become more sophisticated, the use of lookout services as a form of payment for drugs has decreased.[L]
- The methadone treatment respondent reports that users no longer obtain drugs in exchange for injecting services, due to the recent increase in those who snort rather than inject heroin.[M]

WHERE ARE DRUGS USED AND SOLD?

- Heroin and cocaine are used and sold in most of the same settings: crack houses/shooting galleries, private residences, public housing developments, private parties, and inside cars.[L,E] Additionally, these drugs are sold, but not generally used, in open-air markets and in hotels/motels.[L]
- Marijuana is used and sold throughout the city in a variety of settings, including open-air markets; crack houses and shooting galleries; private residences; public housing developments; elementary, junior high, and high schools; college campuses; nightclubs and bars; private parties; hotels and motels; inside cars; and at concerts, raves, and speakeasies.[L,E]
- Diverted OxyContin® is sold in the streets, particularly around drug treatment clinics.[E]
- GHB is sold on college campuses, in nightclubs and bars, at raves, and over the Internet.[E]

As a result of Operation Safe Streets, begun in May 2002, dealing has increasingly moved indoors and into cars, with more home deliveries, cell phone use, and other indoor dealings.[E]

WHO'S SELLING HEROIN?

- The predominant street-level heroin sellers are young adults within organized Dominican gangs; these sellers are also likely to use heroin.[L]
- Dealers communicate with buyers through two-way radios, text messaging, lookouts, and couriers. They publicize cell phone numbers, addresses, and car descriptions via business cards and word of mouth.[L,E]
- Heroin dealers also typically sell marijuana and crack. Sometimes they sell powder cocaine and ecstasy as well.[E]

WHO'S SELLING COCAINE?

- The typical cocaine dealer is involved in an organized structure, particularly Dominican gangs, and engages in both violent and nonviolent criminal acts.[L]
- Powder cocaine dealers tend to be young adults (age 18–30), while crack cocaine dealers tend to be older adults (older than 30).[L]

How much does heroin cost?

Form*	Unit	Price
SA	One bag	$10–$20[L]
	One bundle (10–13 bags)	$70–$200[L]
	1 g	$67–$300[L]
	1 g (multigram purchase	$67[L]
Unspecified	One hit (injection)	$10[E]
	One bag	$20[E]

SA=South American (Colombian)
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 "trey"	$3[E]
	One rock or vial	$3–$10[L]
	One rock	$5[E]
	1 g	$18–$26[L]
Powder	One bag	$10–$20[L]
		$20[E]
	1 g (multigram purchase)	$30[L]
	1 g	$100–$125[L]
	1 oz	$800–$1,300[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	Crack cocaine	Powder cocaine	Marijuana	Methamphetamine	Ecstasy	Diverted OxyContin®	GHB	PCP	Ketamine
Gang-related activity					✓					
Violent criminal acts	✓	✓	✓		✓					
Nonviolent criminal acts	✓	✓	✓		✓					✓
No crimes associated				✓		✓	✓	✓	✓	

Source: Law enforcement respondent

WHO'S SELLING MARIJUANA?

- The typical marijuana dealer is a young adult who also uses the drug, and who deals independently from an organized network.
- Most marijuana sales occur in various central city locations through hand-to-hand transfers. Sales are less visible than before as a result of Operation Safe Streets.
- Marijuana dealers in the city also typically sell heroin, powder cocaine, and crack.

WHO'S SELLING ECSTASY?

- Ecstasy dealers are typically young adults who work independently and also use the drug.[L]
- Ecstasy sales continue in all areas: the central city, the suburbs, and the rural areas.[L]
- Ecstasy sellers are not typically involved in any other criminal activity.[L]

How much does commercial grade marijuana cost?

Unit	Price
One bag	$5–$10[E]
One bag	$5–$35[L]
1 oz	$150–$200[L]

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

All reported prices are stable between spring and fall 2002.

How much does ecstasy cost?

Unit	Price
One pill	$25[E]
One tablet	$20–$35[L]

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

The price of an ecstasy pill rose from $20–$25 each to $25.[E]

How much do other drugs cost?

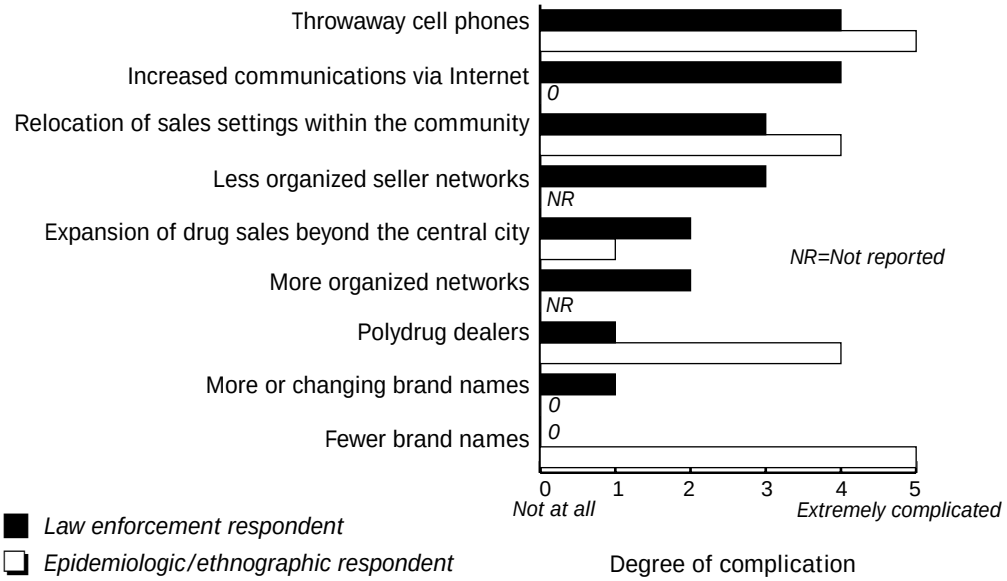
Drug	Unit	Price
Diverted OxyContin®	1 mg	$0.50–$1.25[L] $1–$2[E]
PCP	One bag One fluid oz	$5[L] $250–$350[L]
GHB	One vial or dosage unit	$10–$20[L]
Ketamine	One vial or dosage unit	$10–$20[L]

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

Diverted OxyContin® has risen in price from $1 to $1–$2 per milligram, and is usually sold as 20- and 40-milligram pills.[E] *All other 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 Philadelphia?



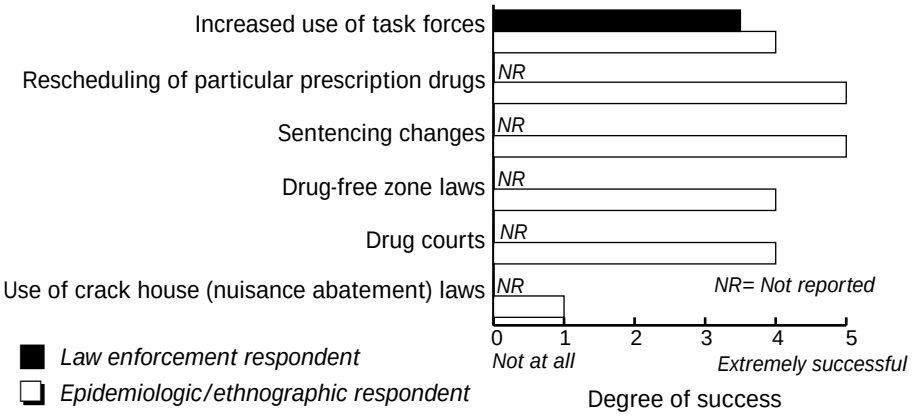
What they have to say...

As mentioned by Pulse Check *sources in many cities, when dealers use unique packaging and brand names, disruption efforts become easier. Such has been the case in Philadelphia.*[E]

What they have to say...

- *Operation Safe Streets identified 200–300 "hot" sales corners. With the stationing of uniformed law enforcement officers at these corners, the markets relocated. Residents were given a telephone number to call and report locations of new markets.*[E]
- *This drug market relocation has had an impact on users: they are more reluctant to go to indoor locations, knock on strangers' doors, or receive home deliveries because of fears about crime or being robbed.*[E]
- *Like many other* Pulse Check *cities that have effectively used task forces, Philadelphia's Drug Enforcement Administration (DEA) task force has made a significant impact on curbing the drug problem as a result of increased expertise among these professionals.*[L]

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



- *In the past decade, the city began its Forensic Intensive Recovery (FIR) program, an effort to reduce prison overcrowding by giving some lower level criminals a conditional release to treatment. FIR has brought more people into treatment over the past 10 years.*[E]
- *In addition to the success of Operation Safe Streets, Operation Sunrise targeted a high-sales area of the city, using both social services and law enforcement personnel. Many people entered treatment as a result.*[E]
- *The rescheduling of prescription drugs, specifically glutethimide (used in combination with liquid cough medicine or Tylenol 4) in the early 1990s, was highly successful in curbing illicit use of the drug.*[E]

SEPTEMBER 11 FOLLOWUP

The residents of Philadelphia were strongly affected by the terrorist attacks of September 11 due to the city's proximity to New York City, as well as to the site of the downed plane in Pennsylvania. The non-methadone respondent believes that an increase in abuse of heroin, crack cocaine, and diverted OxyContin® among clients is attributable to the aftermath of September 11.[N]