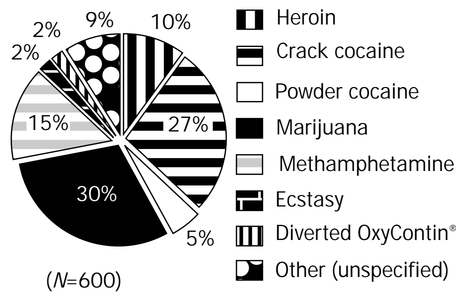
ST. LOUIS METROPOLITAN

STATISTICAL AREA PROFILE:

- Total population: . . . 2,603,607
- Median age: . . . . . . 36.0 years
- Race (alone):
  - White 78.3%
  - Black 18.3%
  - American Indian/ Alaska Native 0.2%
  - Asian/Pacific Islander 1.4%
  - Other race 0.5%
  - Two or more races 1.2%
- Hispanic (of any race): 1.5%
- Unemployment rate: 3.7%
- Median household income: $44,437
- Families below poverty level with children <18 years: 11.2%

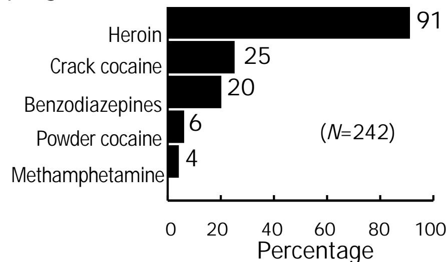
*Source: U.S. Census 2000**

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

Source: Methadone treatment respondent

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

Two *Pulse Check* sources believe the city's overall drug problem is stable,[L,N] while two believe it is somewhat worse.[E,M] Specifically, several developments are reported:

- Community efforts regarding methamphetamine are starting to pay off:
  - Several statewide methamphetamine task forces, mostly through law enforcement agencies, have led to policy and legislation regarding clandestine labs and precursor sales.[E]
  - Legislation has increased penalties for possession of precursors and for methamphetamine manufacture and distribution.[E]
  - Because of legislation regarding sales of ephedrine-based products, large retail stores are flagging anyone who purchases large quantities of cold medicines, and they have been reducing store displays of such products.[E]
- Law enforcement conducted two major seizures involving methamphetamine, marijuana, and cocaine. The drugs originated in Mexico and arrived via Seattle. This is the first time Seattle has been identified as part of the drug trafficking route to St. Louis.[E]
- Emerging problems, such as increased involvement in emergency department mentions, are reported regarding narcotic analgesics (including methadone, hydrocodone, and oxycodone) and phencyclidine (PCP).[E]

Three of the *Pulse Check* sources believe the city's overall drug problem is very serious, while one[L] describes it as "somewhat serious." All but one[M] also agree that marijuana is still the most widely abused drug in St. Louis.[L,E,N] All four sources name crack as the drug related to the most serious or second most serious consequences.

Most widely abused drug:
Marijuana[L,E,N]
Heroin[M]
No reported changes between spring and fall 2002[L,E,N,M]

Second most widely abused drug:
Crack[L,E,M]
Methamphetamine[N]
No reported changes between spring and fall 2002[L,E,N,M]

Drug related to the most serious consequences:
Crack[L,E]
Methamphetamine[N]
Heroin[M]
No reported changes between spring and fall 2002[L,E,N,M]

Drug related to the second most serious consequences:
Crack cocaine[N,M]
Methamphetamine[L]
Marijuana[E]
Changes between spring and fall 2002: Methamphetamine has replaced heroin as the drug associated with the second most serious consequences.[L]

New or emerging problems:
PCP[E]
Narcotic analgesics (hydrocodone, oxycodone, methadone)[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.

SPRING 2002 VS FALL 2002

- *While 30 percent of clients identify marijuana as their primary drug of abuse, 90 percent use it as either a primary, secondary, or tertiary drug.*[N]
- *More primary heroin users in the methadone program are using crack as a substitute for heroin when they cannot afford to purchase heroin.*[M]

**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

Heroin use remains stable in St. Louis.[E,N,M]

COCAINE

Three of the four respondents consider crack cocaine the second most widely abused drug in the city, after marijuana.[L,E,M]

- Crack use remains stable among drug treatment clients,[N,M] except for an increase among primary heroin users: when they cannot afford to buy heroin, they use crack instead.[M]
- Abuse of powder cocaine is stable among all treatment clients.[N,M]

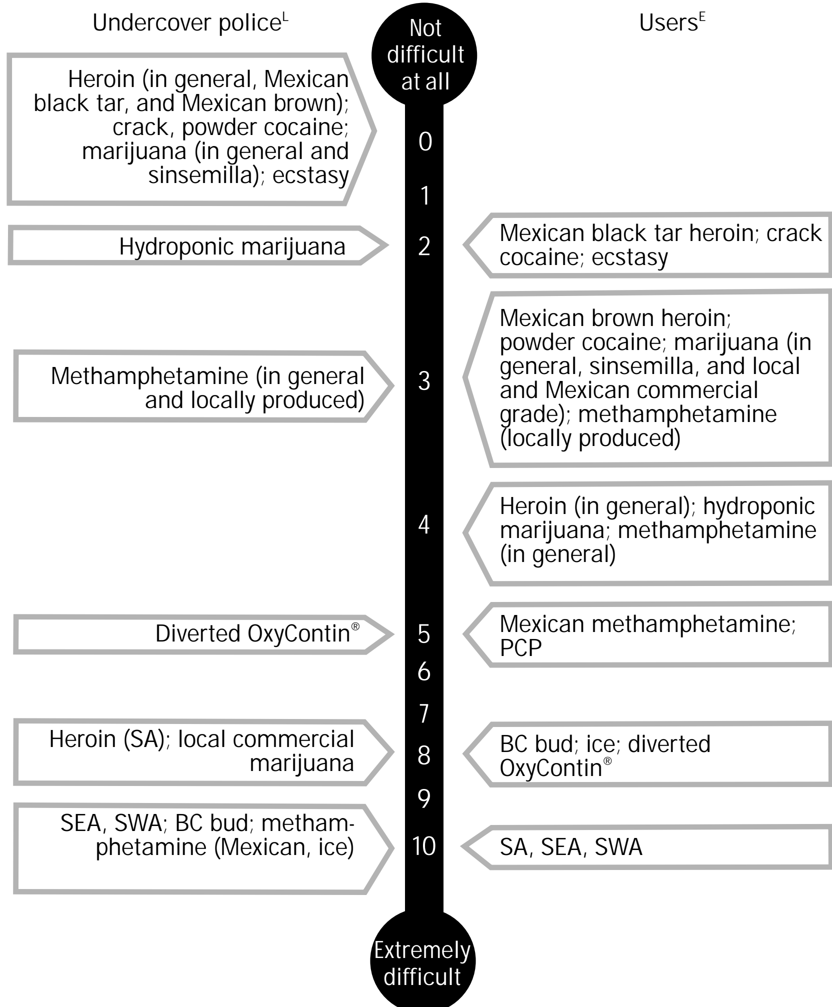
MARIJUANA

Three of the four respondents consider marijuana St. Louis's most widely abused drug.[L,E,N] *Use among treatment clients, however, is stable.*

METHAMPHETAMINE

Methamphetamine emerged as a new problem drug in St. Louis 5 years ago, and as reported in 14 other Pulse Check *cities, the problem continues to grow:*[E]

- Methamphetamine is associated with either the most serious[N] or second most serious[L] drug-related consequences by two respondents, surpassing crack cocaine several years ago according to some treatment providers.[N]
- Most methamphetamine in St. Louis is produced in small mobile "box" labs using either the "cold" (red phosphorus) or "Nazi" (quick-cooking) method.[L]



Sources: [L]*Law enforcement respondent;* [E]*Epidemiologic/ethnographic respondent respondent.*
Note: SA=South American (Colombian) heroin; SEA=Southeast Asian heroin; SWA=Southwest Asian heroin; ice=highly pure methamphetamine in smokable form; and BC Bud=British Columbian marijuana.

- *While users had difficulty purchasing marijuana during October and November 2002, undercover law enforcement did not have any difficulty purchasing the drug.*[L]
- *Diverted OxyContin® (oxycodone hydrochloride controlled-release) and khat were more available in the fall than in the spring.*[L]
- *It became more difficult to purchase gamma hydroxybutyrate (GHB) in the fall.*[L]
- *The availability of liquid ecstasy decreased.*[L]
- *BC bud became more available in recent months (as reported in Minneapolis/St. Paul and Seattle).*[E]
- *While ice could not be purchased at times by users around St. Louis, it became easier to purchase in western Missouri around Kansas City.*[E]
- *St. Louis is the only midwestern* Pulse Check *city where undercover law enforcement found no difficulty in purchasing heroin in general.*[L]

MDMA (ECSTASY)

Methylenedioxymethamphetamine (ecstasy) emerged as a new drug in St. Louis 5 years ago,[L] and there are mixed reports on the nature of the problem today:

- Use among treatment clients remains stable at very low levels.[N,M]
- One source believes that ecstasy use appears to be decreasing,[L] while another observes continued growth in St. Louis's ecstasy problem.[E]

OTHER DRUGS

- Abused methadone: Emergency department (ED) mentions involving methadone have increased.[E] Heroin users often use the drug along with or as a substitute for heroin,[M] and crack users sometimes take methadone along with crack.[N]
- Diverted OxyContin®: Abuse of diverted OxyContin® remains stable at low levels,[N,M] although ED mentions have increased since spring 2002.[E]
- Hydrocodone (Vicodin®): ED mentions involving hydrocodone have increased since spring 2002.[E]
- PCP: The number of PCP users in St. Louis increased between spring and fall 2002. These adolescents and young adults often dip marijuana joints in a PCP solution ("dips").[E]
- Benzodiazepines: Heroin users often take benzodiazepines as a substitute for heroin.[M]
- Khat: This plant from East Africa and Southern Arabia, whose leaves contain psychoactive ingredients structurally and chemically similar to d-amphetamine, increasingly appeared on the drug market since the spring. Law enforcement made three seizures of the drug during fall 2002.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment facility is currently operating at its maximum capacity of 600 clients. The two most common primary drugs of abuse among these clients are marijuana and crack cocaine *(see pie chart on the first page of this chapter)*.[N]
- The methadone treatment respondent is with a program whose current enrollment of 242 clients is nearly at its capacity of 250. One-quarter of its heroin users also use crack *(see bar graph on the first page of this report)*. They are increasingly substituting crack when they cannot afford to buy heroin.[M]
- Treatment slots have become less available and waiting lists have become longer since the spring.[E,N,M] The decrease in treatment slots is due to funding cuts and subsequent closings of private clinics in the area.[E,N] Public methadone programs in particular have long waiting lists (2 months on average).[E]

Barriers to treatment

- State budget cuts are also affecting prevention efforts, and more treatment and prevention programs are in danger of closing.[E]
- A lack of trained staff to treat clients with dual diagnoses remains a significant barrier to effective treatment. While licensed professionals are on staff, there are not enough of them to fully meet the needs of all clients.[N]
- Transportation costs increased as a barrier to treatment for clients in the methadone treatment program. Many of these clients' families have cut off social and financial support. Many receive Supplemental Security Income (SSI) and live on limited incomes.[M]
- Treatment clients are experiencing increased difficulty finding housing opportunities and higher skill sustainable employment.[N] These problems contribute to instability and the likelihood of relapse.

Consequences of drug use

- The incidence of HIV/AIDS among treatment clients has declined since the spring, likely due to education and media attention.[M]
- The incidence of hepatitis C among treatment clients has increased to near epidemic levels. There is a strong need for increased funding to develop more effective treatment for the virus.[N,M]
- The number of clients reporting high-risk pregnancies is extremely high due to referrals from family drug courts[N] and the Division of Family Services.[M]

Co-occurring disorders

- The number of clients presenting with antisocial/conduct,[N] psychotic,[M] and mood[N] disorders has increased, for two reasons:
  - Awareness of comorbidity has increased, leading to more effective diagnoses and to increased referrals from mental health centers.[M]
  - Community mental health programs are not able to effectively handle comorbid clients due to reduced funding, so they end up in drug treatment rather than in mental health treatment.[N]
- The State is currently designing a method to make all mental health and drug treatment programs competent to treat dually diagnosed clients to reduce the strain on both systems.[N]
- The incidence of suicidal thoughts or attempts has decreased since the

spring among methadone treatment clients.[M]

- Attention deficit hyperactivity disorder (ADHD) has increased since the spring, particularly among the younger treatment population. This may be attributable to an increase in diagnoses rather than in the number of people with the disorder.[N]

WHAT HAS CHANGED OVER THE PAST 10 YEARS?

- Users no longer appear to be “maturing out” of their drug use. Instead, more individuals are becoming chronic, long-term drug users. As a result, in addition to more younger people using drugs in recent years, use among older people is getting worse as well.[E]
- Increased court referrals have helped get individuals into needed treatment. The resulting increase in treatment caseloads, however, has made it difficult for case managers and counselors to keep up.[N]
- The normalization of marijuana use has made it difficult to treat marijuana-using clients,[N,M] particularly adolescents, who do not perceive the harm involved.[N] It is also increasingly common for these marijuana-using youth to have marijuana-using parents, making it more difficult to effectively communicate the message of harm related to marijuana use.[N]
- A rise in the availability of crack, heroin, and, most recently, methamphetamine, has complicated the community’s drug problem.[N]
- Polydrug use has increased over the last 10 years, complicating treatment efforts.[M]

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to describe any emerging user groups and to report on how the drugs are used. As shown on the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different populations and use patterns for each drug. For example, all methadone clients are primary opiate users who may use drugs other than opiates in a secondary or tertiary manner.

Who’s most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	38	NR	32
Gender	70% male	60% female	Split evenly
Race/ethnicity	White/Black	White	White
Socioeconomic status	Low	Low	Middle
Residence	Central city	All areas	Suburbs
Referral source	N/A	Criminal justice	Self-referral
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

The proportion of heroin users who are unemployed has increased; many receive SSI.[M]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Snorting/Injecting	Snorting/Injecting
Other drugs taken	Narcotic analgesics, crack cocaine	Marijuana, prescription drugs, methadone	Crack and powder cocaine (speedball)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone	In groups	Both

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

- *The practice of snorting heroin is increasing, particularly among younger users. These youth tend to snort rather than inject because of fears of hepatitis C and HIV.[M]*
- *When speedballing, heroin users inject powder cocaine or smoke crack cocaine.[M] Speedballing is more common among younger users.[E]*
- *Users often take heroin along with marijuana, prescription drugs, or methadone.[E,N] Narcotic analgesics are sometimes used as a substitute for heroin.[E]*
- *Heroin users often take the drug with health food products such as Golden Seal® and milk thistle, water, and diuretics. These substances are generally taken as a way to “cleanse the system,” with users trying to achieve negative drug screens.[M]*
- *While the majority of heroin users take the drug when alone, younger users typically use it in groups.[E]*

Who's most likely to use cocaine?

Characteristic	Crack cocaine			Powder cocaine		
	E	N	M	E	N	M
Age group (years)	18–30	>30	18–30	18–30, >30	>30	>30
Mean age (years)	28	32	NR	32	30	NR
Gender	60% male	Split evenly	Split evenly	60% male	70% male	Split evenly
Race/ethnicity	Black	Black	White	White	White	White
Socioeconomic status	Low	Low	Low	Middle/high	Middle	Middle
Residence	Central city	Central city	Suburbs	Suburbs	Suburbs	Suburbs
Referral source	N/A	Criminal justice	Self-referral	N/A	Criminal justice/self-referral	Self-referral
Level of education completed	N/A	Junior high	Junior high	N/A	High school	High school
Employment at intake	N/A	Unemployed/ part time	Unemployed	N/A	Full time	Full time

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

- *Black crack users in treatment are overrepresented compared with their proportion in the city's population.[E,N] Whites are overrepresented among powder cocaine users.[E]*
- *Methadone treatment clients reporting crack cocaine use are increasingly younger.[M]*
- *Crack users tend to use the drug along with marijuana,[E,N] diverted prescription drugs,[E] alcohol,[E] or methadone.[E] Powder cocaine users take marijuana,[E,N] heroin,[M] or tranquilizers[E] along with cocaine.*
- *In the past, most powder cocaine users entered treatment on their own initiative. Between spring and fall 2002, however, clients have become evenly split between self-referrals and referrals from the criminal justice system.[N]*
- *More crack users in treatment live in the central city since the spring.[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:

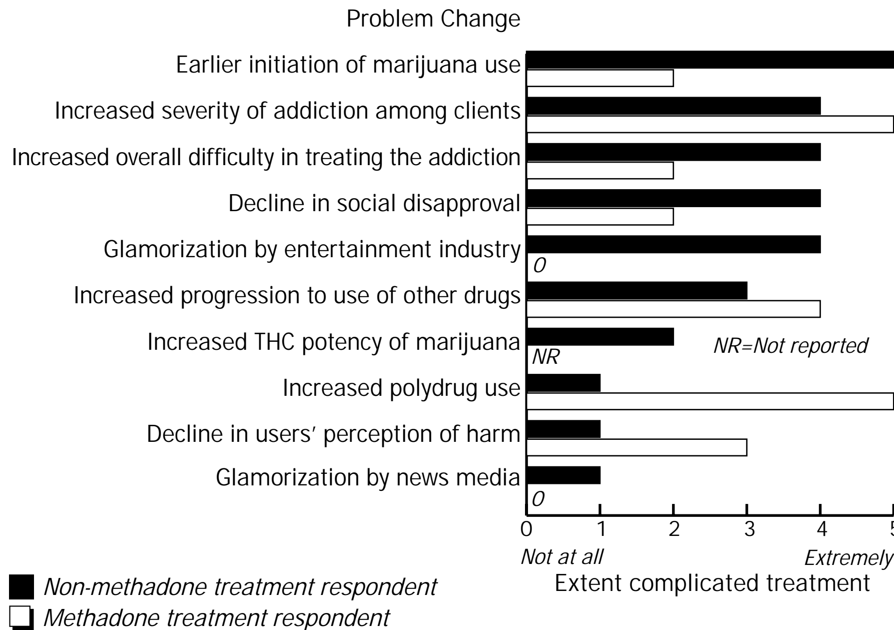
- Drug-related emergency department visits[E,N]
- Drug-related arrests[E]
- Automobile accidents[E]
- Short-term memory loss[N]
- Deteriorating family and social relationships (especially for youth)[E,N]
- Poor academic performance[N]
- School absenteeism or truancy[N]
- Dropping out of school[N]
- Poor workplace performance[E]
- Positive drug screens on the job leading to probation[N]
- Unemployment rates[E]
- Increase in marijuana-induced paranoia[N]

- *Primary marijuana users in treatment generally have a history of abusing hallucinogens, licit drugs, and ecstasy.*[N] *Marijuana users often take crack cocaine, methamphetamine, or alcohol when they smoke marijuana.*[E]
- *Whites and Blacks are equally represented among primary marijuana abusers, but Blacks are overrepresented*[E,N] *and Whites*[E] *are underrepresented compared with the overall St. Louis population.*
- *Marijuana users referred to treatment by the criminal justice system are typically individuals on probation who have a positive urine test.*[N]
- *As is the case in most* Pulse Check *cities, first use of marijuana is occurring at younger ages, representing the most significant complication to treating marijuana addiction among treatment clients—particularly young clients—in St. Louis.*[N]

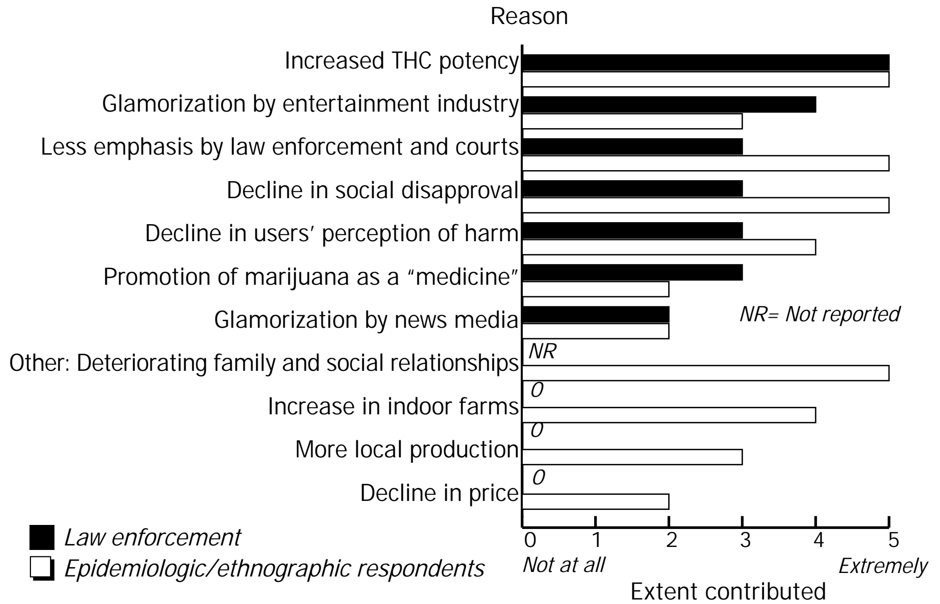
Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	13–17, 18–30, >30	18–30
Mean age (years)	28	23
Gender	70% male	75% male
Race/ethnicity	White, Black	White, Black
Socioeconomic status	Low/middle	Low/middle
Residence	Central city, suburbs, and rural areas	Central city, suburbs, and rural areas
Referral source	N/A	Criminal justice
Level of education completed	N/A	High school
Employment at intake	N/A	All categories

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



- *Severity of addiction and earlier initiation of marijuana use: Many adolescents are using marijuana on a daily basis at increasingly younger ages, which is contributing to the severity of their addiction and, therefore, to the difficulty in treating them.*[N]
- *Social disapproval: One treatment provider believes the inconsistency between parental acceptance and institutional disapproval intensifies the marijuana problem among youth.*[N]
- *Polydrug use: As individuals start using marijuana at younger ages, they also progress to other drugs at earlier ages.*[N]
- *Court referrals: The non-methadone respondent notes that court referrals involving marijuana are actually decreasing due to lessened law enforcement focus on marijuana. Many young clients report that when police stop them, officers simply take away their marijuana and give them a warning. Further, family drug courts do not deal with drug-exposed babies if the only drug involved is marijuana.*[N]



What they have to say...

- *St. Louis sources report many of the same contributors to the marijuana problem as sources in most other* Pulse Check *cities (such as the decline in social disapproval and in users' perception of harm). However, respondents note that, to a greater extent than in any other* Pulse Check *city, increased THC potency contributes to the widespread use of marijuana in St. Louis.*[L,E]
- *While a decline in users' perception of harm contributed to a the drug problem over the past decade,*[L,E] *the public is now becoming more aware of the harm involved in drug use.*[L]
- *At the same time, however, a decline in social disapproval related to marijuana use is one of the most significant contributors to the increasing availability and use of the drug over the past decade.*[E]
- *Rather than declining in price, marijuana has become more expensive due to recent shortages in supply.*[L]
- *According to one source, less emphasis on marijuana by law enforcement and the courts has contributed to more widespread use in the community.*[E]

Who's most likely to use methamphetamine?

Characteristic	E	N	M
Age group (years)	18–30	18–30, >30	18–30
Mean age (years)	26	28	NR
Gender	60% male	75% male	Split evenly
Race/ethnicity	White	White	White
Socioeconomic position	Low	Low	Middle
Residence	Rural areas	Rural areas	Rural areas
Referral source	N/A	Criminal justice	Self-referral
Level of education completed	N/A	Junior high	Junior high
Employment at intake	N/A	Unemployed	Unemployed

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

- *While the majority of methamphetamine users are unemployed, they often make money by manufacturing and selling the drug.*[M]
- *While primary methamphetamine users constitute 15 percent of non-methadone treatment clients, only 1.5 percent of clients from the central city are primary methamphetamine users. However, the drug is the primary drug of abuse for 35 percent of clients from rural areas.*[N]
- *The proportion of Whites among primary methamphetamine users in St. Louis is an overrepresentation of their proportion in the city's overall population.*[E]

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	13–17, 18–30	18–30
Median age (years)	23	NR
Gender	60% male	Split evenly
Race/ethnicity	White	White
Socioeconomic position	Middle/high	Middle
Residence	Suburbs	Suburbs
Referral source	N/A	Criminal justice
Level of education completed	N/A	High school
Employment at intake	N/A	Full time, part time, full-time students

Sources:[E] Epidemiologic/ethnographic and [N] Non-methadone treatment respondents.

- *The number of clients in treatment for primary ecstasy abuse is stable at low levels (about 2 percent of the treatment population).[N]*
- *White ecstasy users are overrepresented relative to the overall community population.[E,N]*

WHO'S MOST LIKELY TO USE OTHER DRUGS?

- Diverted OxyContin®: Individuals who primarily abuse OxyContin® are older than 30, split evenly between genders, live in the suburbs, and split between low and middle class. These individuals tend to abuse other prescription opiates, and some are previous heroin addicts.[N]
- PCP: Adolescents and young adults are the most common users of PCP, and the majority are Black females. Users often dip marijuana joints in a PCP solution, a combination referred to as "dips."[E]
- Benzodiazepines: Benzodiazepines are often abused as a substitute for heroin. Abusers are typically White female adults living in the suburbs.[M]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, crack cocaine, and marijuana are sold in most of the same settings, including street markets; crack houses/shooting galleries; private residences; public housing developments; elementary, junior high and high schools; nightclubs/bars; shopping malls; playgrounds/parks; and private parties. Heroin and crack are also sold in hotels/motels and around drug treatment clients, while marijuana transactions take place on college campuses, at raves and concerts, and inside cars.[L,E]

Most sales settings are also use settings for marijuana and crack. Heroin use is typically limited to street markets, shooting galleries, private residences, public housing developments, and nightclubs/bars.[L,E]

Powder cocaine is sold in fewer settings than crack cocaine. It is used primarily in private residences, at college campuses and nightclubs/bars, and inside cars.[L,E]

Methamphetamine is sold in private residences, playgrounds/parks, private parties, hotels/motels, truck stops, and over the Internet. Use is generally confined to private residences, hotels/motels, and truck stops.[L,E]

Ecstasy is used and sold in private residences; at college campuses, nightclubs/bars, private parties, raves, concerts, and hotels/motels; and inside cars.[L,E]

HOW DO DRUGS GET FROM SELLER TO BUYER?

Heroin and cocaine are typically sold through hand-to-hand transactions in known locations,[L,E] while larger amounts are transferred at scheduled meeting places such as fast food restaurant parking lots.[L] Sales involving powder cocaine tend to be more high-tech and hidden than those involving crack cocaine.[E] Buyers and sellers of heroin and cocaine communicate via pagers, cell phones, and walkie-talkies.[L,E]

While heroin and cocaine transactions are generally conducted in the central city, marijuana sales are equally distributed between the central city, the suburbs, and rural areas.[L,E] Marijuana dealers tend to

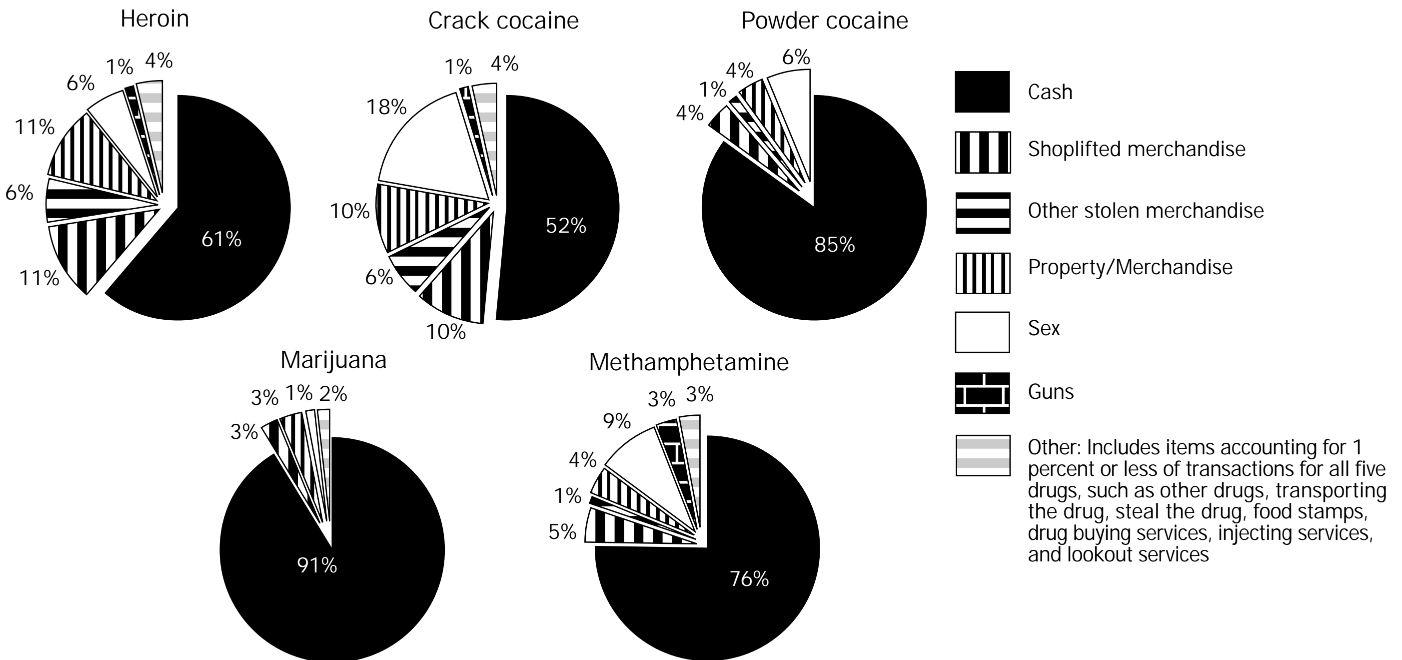
have more of a relationship with their buyers than other drug dealers; they are often family members, friends, or acquaintances.[E] Most marijuana found in St. Louis is locally produced in basements using the hydroponic method.[L] The marijuana grown outdoors typically comes from Mexico.[L]

Methamphetamine transactions usually take place in rural areas,[L,E] but production of the drug is moving more to the central city[E]. Methamphetamine sales take place within small networks of family and friends, often in public venues such as truck stops.[E] Buyer and seller communicate through telephones and pagers, and in places like fast food restaurant parking lots. Dealers generally do not sell other drugs.[L,E]

Ecstasy and GHB dealers sell the drugs in both central city and suburban settings through hand-to-hand transactions.[L,E] While ecstasy transactions used to be exclusively associated with raves, they are now moving to the suburbs and rural areas.[E] Ecstasy is sold at concerts, colleges, and high schools, and dealers are easily identified.[E] Outside of these impromptu transactions, dealers communicate with buyers via pagers and networking. They often make home deliveries.[L]

For all drugs, dealers communicate with each other using the "walkie-talkie" feature of new cell phones. Law enforcement is currently working to intercept this new technology.[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...

- *The practice of exchanging sex for crack cocaine[L,E] and for methampetamine[E] has increased over the past decade.*
- *A recent ethnographic study in rural southwest Missouri revealed two common settings where users exchange sex for drugs: truck stops and libraries/book stores.[E]*
- *A decade ago, cash was typically the only form of payment accepted for crack cocaine. Now, crack dealers commonly accept sex or merchandise for payment.[L]*
- *Like in many other cities, (such as Atlanta, Boston, Phoenix, Seattle, and San Francisco), shoplifted merchandise in St. Louis represents a significant proportion of currency for purchasing heroin. It is also often traded for crack (as in Boston, Dallas, Houston, and Seattle).*

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Methamphetamine	Ecstasy
Gang-related activity	✓	✓		✓	✓	
Violent criminal acts	✓	✓	✓	✓	✓	
Non violent criminal acts	✓	✓		✓	✓	✓
Prostitution		✓			✓	
Domestic violence		✓	✓		✓	
No criminal involvement						✓

Sources: Law enforcement respondent; epidemiologic/ethnographic respondent

- *More armed robberies are associated with crack cocaine dealers than with dealers of other drugs.*[E]
- *Both male and female methamphetamine sellers/buyers engage in prostitution.*[E]

WHO'S SELLING HEROIN?

- Heroin dealers are younger[L,E] or older adults[L] working either independently[L] or as part of organized structures, particularly gangs.[L,E] Their criminal activity includes violent crimes involving weapons, and nonviolent crimes such as larceny and robbery.[E]

How much does heroin cost?

Unit	Price
1 mg	$3.53[E]
1 g	$100[L] $250–$600[E]

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

- *The price for a milligram of heroin increased from $2.72 to $3.53.*[E]

WHO'S SELLING COCAINE?

- Powder cocaine dealers tend to work independently. They are typically young adults who often use powder cocaine themselves.[L]
- Crack cocaine dealers work both independently[L] and as part of organizations, particularly gangs.[L,E] There is some overlap between the gangs selling heroin and crack cocaine.[E]
- Crack dealers range in age from younger[L,E] to older adults,[L] and may[E] or may not[L] use crack themselves.

How much does cocaine cost?

Form	Unit	Price
Crack	Rock 1 g	$20[L,E] $300–$400[E]
Powder	1 g	$100[L] $100–$125[E]

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

- *Powder cocaine purity is estimated to be 77 percent.*[E]
- *While crack cocaine generally costs $300–$400 per gram, it is sold for as little as $250 per gram in rural areas.*[E]
- *All reported prices are stable between spring and fall.*[L,E]

WHO'S SELLING MARIJUANA?

- The young adults selling marijuana generally work independently.[E] Older dealers work either independently or as part of a larger organization trafficking marijuana from Mexico.[E]
- Marijuana dealers are almost always marijuana users as well.[L,E]

How much does marijuana cost?

Unit	Price
Small bag	$20
1 oz	$100
1 lb	$1,000–$1,100

Source: [L]Law enforcement respondent

- *The price of marijuana increased from $700–$850 per pound in the spring to $1,000–$1,100 per pound in the fall.*[L]

WHO'S SELLING METHAMPHETAMINE?

- Most methamphetamine dealers identified by law enforcement work independently and are very likely to be users as well.[L]
- The epidemiologic source describes methamphetamine dealers as young adults who fall into two categories:
  - Those selling locally produced methamphetamine work independently and are very likely to user the drug.[E]
  - Those selling Mexican methamphetamine work as part of an organization, and are not likely to use methamphetamine themselves.[E]

How much does methamphetamine cost?

Unit	Price
1 g	$100[L] $37–$100[E]
1 oz	$700–$1,300[E]

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

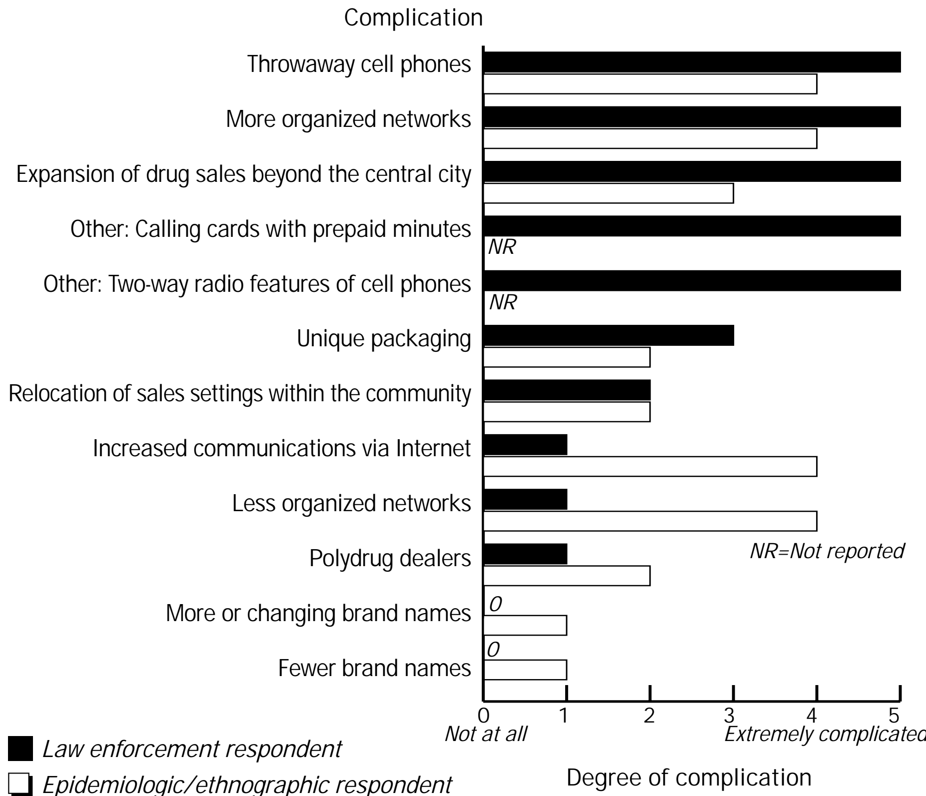
- *The cost of methamphetamine is higher in the suburban and rural areas than in the central city.*[E]
- *Generally, methamphetamine is sold in increments priced at $100 and higher.*[L]

WHO'S SELLING OTHER DRUGS, AND HOW MUCH DO THEY COST?

- Ecstasy: Dealers generally work independently and are likely to be users as well.[L,E] The cost of an ecstasy pill ranges from $20–$30[E] to $100.[L]
- GHB: Individuals selling GHB are typically young adults who work independently and do not use the drug.[L] A capful of GHB costs $5, while an ounce sells for $40.[E]
- PCP: One fluid ounce of PCP currently sells for $350.[E]

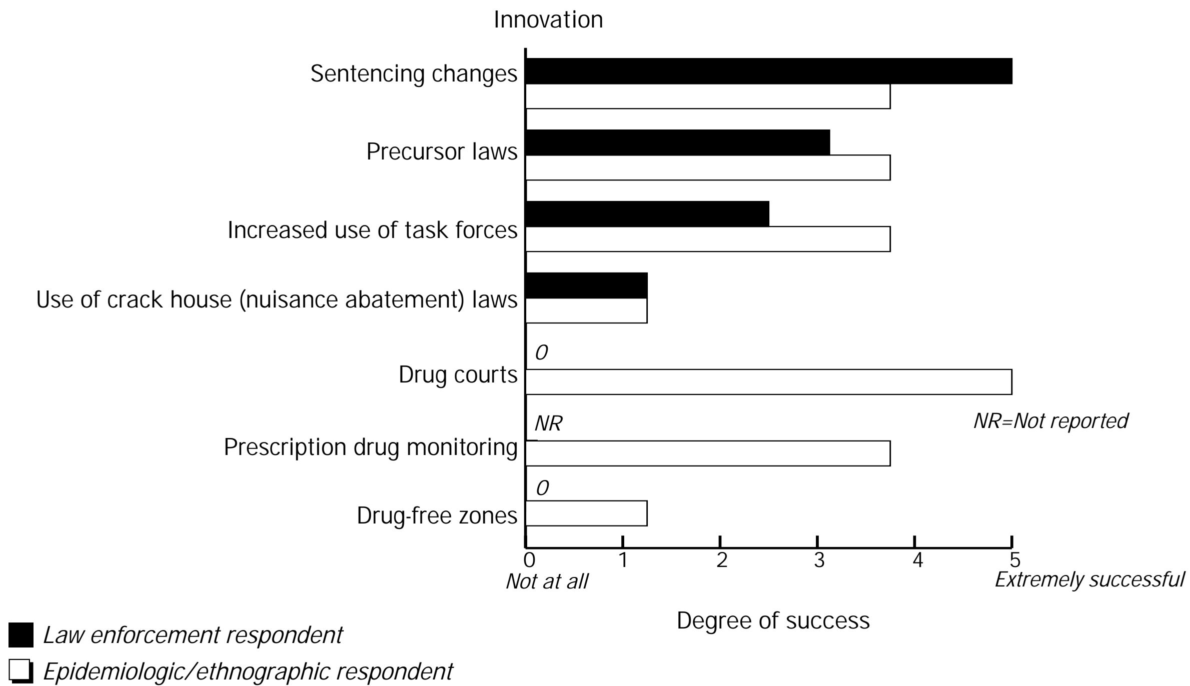
THE MARKET PERSPECTIVE: A 10-YEAR VIEW

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



What they have to say...

- *As in the majority of* Pulse Check *cities, advances in technology, such as cell phones and the Internet, have greatly complicated efforts to combat the community's drug problem.*[L,E]
- *Most recently, dealers have become cautious about using traditional cell phones. Instead, they are using disposable cell phones, cell phones with "walkie-talkie" features, and prepaid calling cards. These practices make it difficult for law enforcement to write affidavits on wiretaps.*[L]
- *There is great concern that recent movies and media exposés have revealed law enforcement secrets (such as cloning phones and cloning pagers) to the public, causing drug dealers to change their practices.*[L]
- *One source believes that telephone companies offer their new technologies to the public before supplying the government with counter technology.*[L]



What they have to say...

- *Sentencing changes, particularly with respect to penalties involving possession of methamphetamine precursors and manufacture and distribution of methamphetamine, have been largely successful in St. Louis.*[L,E]
- *Recent precursor laws involving ephedrine and ephedrine-based products have been effective. For example, a large national retail chain now "flags" anyone who purchases large quantities of cold medicine, and has reduced store displays of such products.*[E] *The success of these laws in curtailing trafficking of ephedrine products is similar to the progress reported in San Diego.*
- *Multijurisdictional enforcement efforts have met with some success in combating the methamphetamine problem.*[L,E] *These efforts involve shutting down clandestine labs and monitoring precursor chemicals.*[E]
- *Missouri is third in the Nation in the number of drug courts, which one source believes have been highly effective.*[E] *Another source, however, rates them as unsuccessful.*[L]
- *Recommended innovations in St. Louis are (1) more training in pharmacy schools about prescription drug abuse, prescription fraud scams, and diversion techniques,*[E] *and (2) construction of larger jails.*[L]

SEPTEMBER 11 FOLLOWUP

The treatment respondents do not observe any continuing effects of the September 11 attacks on treatment clients. The law enforcement and epidemiologic/ethnographic respondents, however, note two continued effects:

- Drug trafficking: Tightened security as a result of the September 11 attacks has continued to change the way drugs are transported. Rather than carrying drugs aboard airplanes in luggage and on their person, traffickers are relying more on automobile transport.[L]
- Drug use: Although not exclusively related to September 11, ripple effects of the economy have impacted the drug abuse problem.