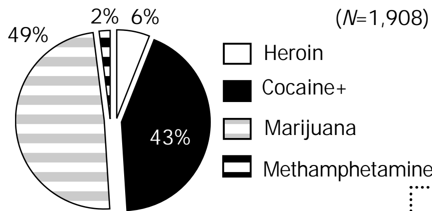
TAMPA/ST. PTERSBURG METROPOLITAN

STATISTICAL AREA PROFILE:

- Total population: . . . 2,395,997
- Median age: . . . . . . 40.0 years
- Race (alone):
  - White 82.9%
  - Black 10.2%
  - American Indian/ Alaska Native 0.3%
  - Asian/Pacific Islander 2.0%
  - Other race 2.7%
  - Two or more races 2.0%
- Hispanic (of any race): 10.4%
- Unemployment rate: 2.9%
- Median household income: $37,406
- Families below poverty level with children <18 years: 12.7%

*Source: U.S. Census 2000**

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



+The program doesn't distinguish between crack and powder cocaine, but crack is the predominant form of cocaine used.

Source: Non-methadone treatment respondent

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

Three of the four *Pulse Check* sources believe the city's overall drug problem has remained stable since the previous reporting period,[L,E,M] while one believes the situation has worsened somewhat.[N] Specifically, several developments are reported:

- A Meth Squad has been introduced and has successfully seized many labs in a nearby rural county that serves as the source for Tampa's methamphetamine supply.[E] Nevertheless, methamphetamine continues to be reported as an emerging problem.[L]
- Community efforts are gearing up to combat another emerging problem: diverted pharmaceuticals are becoming increasingly available on the street, much more than a year or two ago, since pain management clinics began opening up "right and left."[M] Methadone, in particular, is increasingly involved in emergency department episodes and deaths.
- Similar to reports in other cities (such as Denver[E] and Portland, OR[L]), "triple C" is what adolescents call dextromethorphan (found in the over-the-counter product Coricidin HBP Cold and Cough®). The drug supposedly produces effects similar to those of ecstasy when taken in large doses and is sometimes combined with dimenhydrinate (found in the over-the-counter product Dramamine®). A recent community alert, corroborated by law enforcement, reports an increase in thefts of the product from groceries and pharmacies and describes adolescents taking 20 to 43 tablets at a time.[N] Pharmacies are starting to display signs noting restriction of sales to one box per customer.[M]

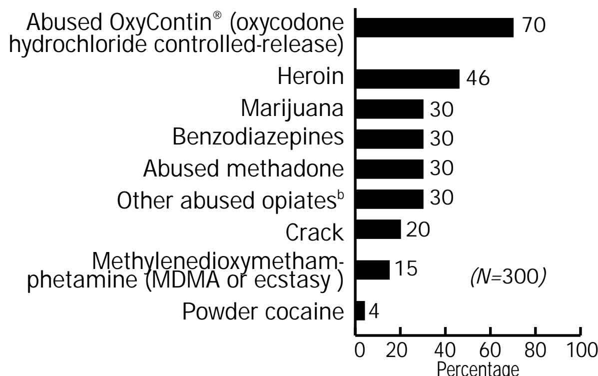
Several longer term changes are reported:

- Crack was merely an emerging problem 5 years ago: now it has replaced powder cocaine as the most widely abused drug.[L]
- Over the past 5 years, OxyContin® abuse has replaced heroin as the most widely abused drug among clients in the *Pulse Check* source's methadone program.
- Because of increased training, more treatment staff are aware of comorbidity problems and how to approach them.[M]

Three of the sources consider the city's drug problem very serious,[L,E,M] and one describes it as "somewhat serious."[M] Because of the different populations with whom they have contact, the sources vary in their perception of which drugs are most commonly abused and which have the most serious consequences.

- *Ecstasy use among methadone clients, both older and younger, has declined somewhat.*[M]
- *Treatment percentages in both programs remained stable between spring and fall 2002.*[N,M]

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



[a] Includes any use, whether as a primary, secondary, or tertiary drug

[b] Includes hydrocodone, morphine, and fentanyl patches

Source: Methadone treatment 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.*

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

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

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

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

Drug related to the most serious consequences:
- Cocaine (in general)[L]
- Crack[E]
- Heroin[N]
- Diverted OxyContin®[M]

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

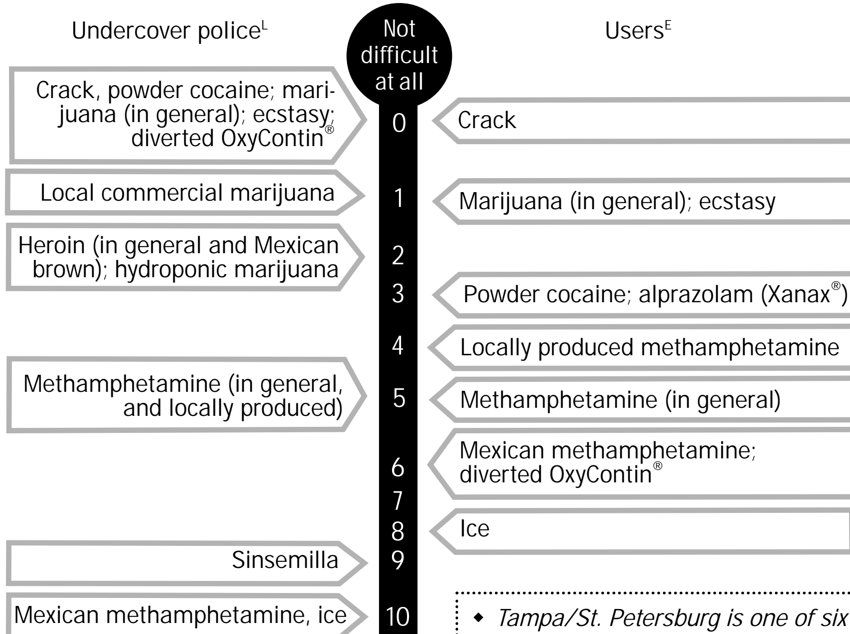
Drug related to the second most serious consequences:
- Heroin[L,M]
- Prescription pills[E]
- Crack[N]

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

New or emerging problems:
- Methamphetamine[L]
- Prescription pills (especially diverted alprazolam [Xanax®] and OxyContin®)[E]
- Dextromethorphan (in Coricidin HBP Cough and Cold®) plus dimenhydrinate (in Dramamine®) [N,M]
- Diverted methadone[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 respondents.

How difficult is it for undercover police and users to buy drugs? (Fall 2002)



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

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

- *Tampa/St. Petersburg is one of six* Pulse Check *areas where sources believe diverted OxyContin® can be obtained with no difficulty at all. (The other five are Boston*[L]*, Dallas*[E]*, New York*[L]*, Pittsburgh*[E]*, and San Francisco*[L]*).*
- *Undercover police find it less difficult to obtain locally produced methamphetamine in fall 2002 than in the previous spring.*[L]
- *Users find no change in difficulty of obtaining drugs since the last reporting period.*[E]
- *Users and undercover police generally have a fairly similar degree of difficulty in purchasing most drugs.*

HEROIN

- No changes are reported in the numbers or characteristics of users between spring and fall 2002.
- While injecting is the primary route of administration, smoking has increased over the past 5 years.[E] Snorting, however, is the most common route of administration in the *Pulse Check* source's non-methadone program,[N] and a substantial number of methadone patients snort heroin.[M]

COCAINE

- Since the last reporting period, the number of crack users has increased slightly, while the number of powder cocaine users has declined slightly.[E]
- Treatment percentages, however, remained stable, as did client demographics and use patterns.[N,M]

MARIJUANA

- The percentages of primary, secondary, or tertiary marijuana use remained stable in both treatment programs between spring and fall 2002.[N,M]
- Respondents report no changes in the difficulty of users or undercover police to obtain the drug.[L,E]

METHAMPHETAMINE

- The number of users is stable, as is their ability to obtain drugs since the last reporting period.[E]
- Undercover police find it less difficult to obtain locally produced methamphetamine in fall 2002 than in the previous spring.[L]

MDMA (ECSTASY)

Two sources observe very different populations:

- One has been seeing increasingly younger users over the past 5 years.[E]
- Another believes the people "outgrow it, mature out."[M] Further, that source perceives a decline in ecstasy use even among younger people.

DIVERTED METHADONE

- The methadone treatment source observes a large increase in methadone-positive drug screens on intake: 26 percent positive in the last quarter of 2002—previously, positive findings were a rarity.[M]
- The users involved are coming from pain management clinics whose doctors started prescribing methadone instead of OxyContin® because of all the "bad press" OxyContin® has received and because methadone is cheaper and more effective.[M]
- The respondent notes that "tons are on the street" in a city that never had a diversion problem before pain clinics started advertising and writing prescriptions "for anything you want."[M]
- Emergency department episodes and deaths involving methadone have also increased.[M]
- Community efforts are starting to deal with increased methadone diversion and abuse. A proposed first step is to send letters to doctors around the State, warning them about the problem.[M]

DIVERTED OXYCONTIN®

- Tampa/St. Petersburg is one of six *Pulse Check* areas where sources believe diverted OxyContin® (known as "omego"[N]) can be obtained with no difficulty at all. (The other five are Boston[L], Dallas[E], New York[L], Pittsburgh[E], and San Francisco[L]).
- Half of the clients in the methadone program abuse OxyContin® as their primary drug, and 70 percent report either primary, secondary, or tertiary abuse.
- Many OxyContin® abusers have no history of drug use. They start out with legitimate prescriptions for pain, and become addicted.

OTHER DRUGS

- Diverted pharmaceutical opiates (in general): A subset of 35–40 percent of clients in the methadone clinic are people who start out with a chronic pain problem, go to a pain management clinic to receive pain medication, become addicted to the medication, are expelled from the chronic pain program, and then seek help in the methadone clinic. Those individuals often "go into business" by presenting to a second pain management clinic to obtain additional drugs, which they sell.
- Benzodiazepines: A large increase is reported in the abuse of benzodiazepines, particularly alprazolam. The diverted drug is commonly available on the street in the form of "footballs" (30-day supplies of 1-milligram blue pills). Sometimes 2-milligram pills are also sold as "bars."[E]
- "Triple C": An increase in overdoses involving a product containing dextromethorphan (Coricidin HBP Cough and Cold®), which used to be rare, is reported at the juvenile facility associated with the methadone clinic.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- Program descriptions, capacity, and treatment availability: The *Pulse Check* non-methadone treatment source is with a large facility that includes several programs, including outpatient, residential, adolescent, criminal justice outpatient, and short-term treatment. With an enrollment of 500, it is operating below its capacity of approximately 1,100. Located in an affluent county, this particular program has clients at the lower end of the socioeconomic scale, and Blacks are overrepresented. Nearly half of the clients report marijuana as their primary drug of abuse, and more than 40 percent report some form of cocaine (most likely crack) as such *(see pie chart on the first page of this chapter)*.

  The methadone treatment source is with one of the many programs operated under the same umbrella as the non-methadone source. Information provided for this issue of *Pulse Check* is based on 300 patients enrolled during the last quarter of 2002. This program is one of the few among those in the other *Pulse Check* sites where abused OxyContin® accounts for more abuse than does heroin *(see bar graph on the first page of this chapter).*

  Methadone maintenance treatment is available throughout the area, particularly since the recent opening of the large program with which both *Pulse Check* treatment sources are affiliated. Treatment capacity has remained stable between spring and fall 2002.[E]
- Drug abuse consequences: Drug overdoses have recently increased, particularly those related to methadone on the street. Methadone has unique properties which,

when used by opiate-naive people, can have dangerous consequences. Often even opiate-experienced people are methadone naive because they don't know exactly how they will react.[M] The other treatment source similarly reports an increase in drug overdoses, attributing them to more potent illegal drugs.[N]

Both treatment sources note an increase in drug-related automobile accidents, most involving young adolescents who "hang out" with older teens or parents.[N,M]

Tuberculosis, while fairly rare, may have increased slightly. Both treatment sources believe the increase might be related to increased homelessness.[N,M]

- Decreased barrier to treatment: Because of increased training, more people are aware of comorbidity problems and how to approach them, thus decreasing what had been a relatively common barrier to treatment.[N,M]
- Changes over the past 10 years: More than any other change over the past decade, the appearance of MS Contin® (morphine sulfate) and OxyContin® on the drug scene has been the most complicating factor in the community's drug abuse problem.[N,M] Other important changes include the earlier first use of more dangerous drugs,[N,M] the normalization of drug use,[N] increased court referrals to treatment,[N] and increased polydrug use.[N]

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)	18–30	>30	>30
Gender	NR	69% female	65% male
Race/ethnicity	NR	White	White
Socioeconomic status	Low	Middle	Middle
Residence	Central city	Suburbs	Suburbs
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	NR	Full time

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

- *Among first-time methadone admissions, approximately 15 percent report heroin as their primary drug of abuse.*[M]
- *Atypical of non-methadone programs described in most other* Pulse Check *sites, the majority of primary heroin abusers in this program are female.*[N]
- *Atypical of methadone programs described in most other* Pulse Check *sites, only 19 percent of the clients are primary heroin abusers— while about half are primary OxyContin® abusers.*
- *No changes are reported in the numbers or characteristics of users between spring and fall 2002.*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Snorting	Injecting
Other drugs taken	NR	NR	Powder cocaine (speedballs)
Publicly or privately?	Privately	NR	Privately
Alone or in groups?	In groups/ among friends	NR	Both

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

- *While injecting is the most common primary route of administration, smoking has increased over the past 5 years,*[E] *and a substantial number of methadone patients snort heroin.*[M]
- *Snorting, however, is the most common route of administration among the non-methadone clients.*[N]

Who's most likely to use cocaine?

Characteristic	Crack cocaine			Powder cocaine	
	E	N*	M	E	M
Age group (years)	>30	>30	>30	18–30	18–30
Mean age (years)	34	NR	NR	NR	NR
Gender	60% male	53% female	NR	Split evenly	Split evenly
Race/ethnicity	Black	White	White	White	White
Socioeconomic status	Middle	Middle	Low/middle	Middle	Low/middle
Residence	Central city	Suburbs	Suburbs	Central city/Suburbs	Suburbs
Referral source	N/A	Criminal justice	Individual	N/A	Individual
Level of education completed	N/A	High school	High school	N/A	High school
Employment at intake	N/A	NR	Full time	N/A	Full time

**The program doesn't distinguish between crack and powder cocaine, but crack is the predominant form of cocaine used.*

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

- *Since the last reporting period, the number of crack users has increased slightly, while the number of powder cocaine users has declined slightly*[E]
- *Treatment percentages, however, remained stable, as did client demographics and use patterns.*[N,M]
- *Methadone clients combine powder cocaine with heroin (in speedballs), but they use crack without other drugs.*[M]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–17, 18–30	13–17	18–30
Mean age (years)	23–24	NR	NR
Gender	NR	62% male	Split evenly
Race/ethnicity	White, Black	White	White
Socioeconomic status	Low/middle	Middle	Low/middle
Residence	All	Suburbs	Suburbs
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	NR	Full time

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

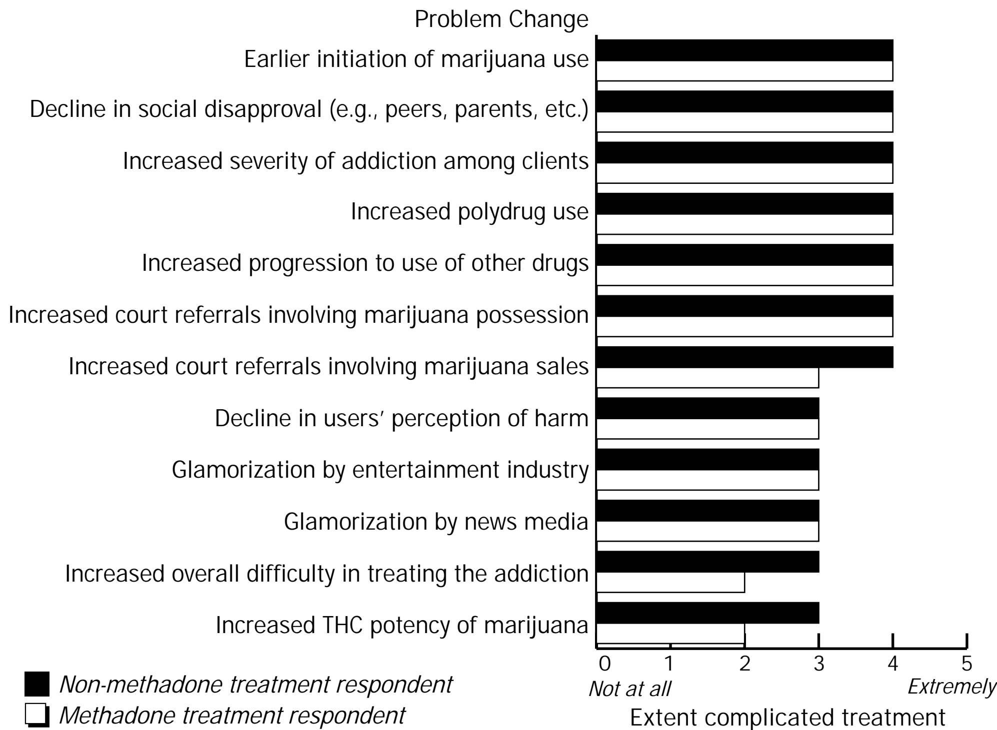
- *Nearly half of the clients in the non-methadone treatment program report marijuana as their primary drug of abuse.*[N]
- *The percentages of primary, secondary, or tertiary marijuana use remained stable in both treatment programs between spring and fall 2002.*[N,M]
- *Clients in both treatment programs generally smoke marijuana in joints,*[N,M] *although blunts are common in a related juvenile facility.*[M]
- *Joints and blunts are the most common delivery vehicles. Younger, lower socioeconomic central city users tend to use blunts. Suburban, middle-to-upper socioeconomic users tend to use pipes.*[E]
- *Sources report no specific marijuana combinations.*

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Marijuana, in combination with other drugs, has recently been involved in an increasing number of deaths and emergency department episodes.[E]
It is also associated with the following consequences, either alone or with other drugs:

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

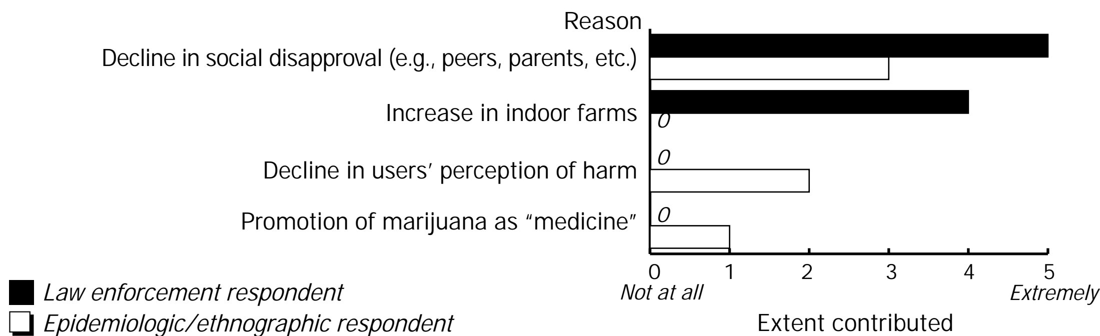
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

- *The two treatment sources are remarkably similar in their opinions about which changes have most and least complicated the treatment of marijuana users.*
- *Like many of their counterparts in other* Pulse Check *cities, both treatment sources attribute importance to the earlier initiation of marijuana use. By contrast, Tampa/St. Petersburg sources attribute somewhat greater importance than sources in most other* Pulse Check *cities to increased court referrals involving marijuana possession.*
- *With regard to the decline in social disapproval, one source elaborates: "Parents are not as concerned as they should be."*[N]

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



What they have to say...

- *Similar to the average opinion of their counterparts in other* Pulse Check *cities, the sources place the decline in social disapproval of marijuana as the most significant change over the past 10 years.*[L,E]
- *As reported in many other* Pulse Check *cities, prices have remained stable, and thus have not contributed to increases in marijuana use or availability.*[L]
- *Law enforcement and court emphasis has remained stable over the past 10 years—unlike in many other* Pulse Check *cities, where such emphasis has declined.*[L]
- *Most marijuana continues to be grown indoors.*[L]
- *Local production is at about the same level as it was 10 years ago.*[L,E]

WHO'S MOST LIKELY TO USE METHAMPHETAMINE, AND HOW DO THEY TAKE IT?

Methamphetamine users tend to be White[E,N] young adults (18–30 years)[E] or older adults (older than 30).[E,N] They are equally likely to be male or female,[E,N] they are generally from middle socioeconomic backgrounds,[E,N] and they live either in rural[E] or suburban[N] areas. Primary methamphetamine users account for only about 2 percent of clients in the non-methadone program, and the methadone program has no methamphetamine users. The epidemiologic source reports a stable number of users.

Clients in the non-methadone program generally take methamphetamine orally.[N] The epidemiologic source, however, reports that injecting is the most common primary route of administration, followed by smoking and snorting. The drug is generally taken privately in small groups or among friends, and it is sometimes taken with marijuana or alprazolam[E].

Who's most likely to use ecstasy?

Characteristic	E	M
Age group (years)	All groups	13–17, 18–30
Mean age (years)	22	NR
Gender	Split evenly	Split evenly
Race/ethnicity	White	White
Socioeconomic status	Middle	Low/middle
Residence	All areas	Suburbs
Referral source	N/A	Individual
Level of education completed	N/A	Junior high
Employment at intake	N/A	Full time

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

- *Ecstasy use is not recorded on intake to the non-methadone program.[N]*
- *Approximately 15 percent of clients in the methadone program use ecstasy.[M]*
- *Ecstasy users also take other club drugs,[M] powder cocaine,[E] and prescription pills such as clonazepam (Klonopin®) and alprazolam.[E]*
- *Two sources observe very different populations. One has been seeing increasingly younger users over the past 5 years.[E] Another believes the people "outgrow it [ecstasy], mature out."[M] Further, that source perceives a decline, even among younger people.*

WHO'S MOST LIKELY TO USE OTHER DRUGS?

- Diverted OxyContin®: The many methadone clients whose primary drug of abuse is OxyContin® tend to be male (about 65 percent), White, and older than 30 years. They tend to live in the suburbs, come from both low and middle socioeconomic backgrounds, and are equally likely to snort or inject the drug.[M] The epidemiologic source agrees that users tend to be White middle-socioeconomic suburbanites, but reports that abusers tend to take the drug orally and that they come from all age groups, with an average age of early twenties. Many of these people start out with legitimate prescriptions for pain, and then become addicted. This source cites an example of one young professional woman, with no history of drug use, who took the drug as prescribed after kidney surgery and subsequently became addicted.[E]
- Abused benzodiazepines: Alprazolam abusers tend to be White[E,N,M] females[E,N]. The epidemiologic source observes more younger abusers (17–25 years) than do the non-methadone (older than 30) and methadone (18–30 and older than 30) treatment sources. Pills are sometimes consumed with alcohol.
- Other abused opiates: A stable proportion of about 30 percent of clients in the methadone program abuse hydrocodone, morphine, or fentanyl patches. They tend to be White, suburban, low-to-middle socioeconomic young adults and older adults and are equally likely to be male or female.[M]

THE MARKET PERSPECTIVE

WHO'S SELLING DRUGS, AND HOW?

Most drugs are sold hand to hand at meetings prearranged through an intermediary. Cell phones are generally involved.[L,E] Additionally, mail transactions are reported for methamphetamine, OxyContin® (both pills and "scripts"), and alprazolam (both pills and scripts).[E]

Dealers in Tampa/St. Petersburg tend to sell more than one drug:[L]

- Heroin dealers also sell crack and powder cocaine.
- Crack dealers also sell powder, cocaine, marijuana, and ecstasy.
- Powder cocaine dealers also sell crack, marijuana, and ecstasy, as well as diverted pharmaceutical drugs.
- Marijuana dealers also sell crack, powder cocaine, and diverted pharmaceuticals.
- Ecstasy dealers also sell diverted pharmaceuticals.

According to the law enforcement source, street-level sellers of heroin, crack, powder cocaine, and marijuana tend to be young adults (18–30 years) who operate independently. Ecstasy sellers also operate independently, but they include adolescents as well as young adults. Heroin sellers are somewhat likely to use their own drug; crack, powder cocaine, marijuana, and ecstasy sellers are very likely to do so.[L]

The epidemiologic source paints a somewhat different picture. Crack dealers are organized, and they are generally older than 30. They are involved in gang-related activity, violent criminal acts, nonviolent criminal acts such as theft, domestic violence, and drug-assisted rape. Marijuana dealers do resemble the other source's description and are involved in nonviolent criminal acts such as theft and shoplifting. Ecstasy dealers are reported as organized, rather than independent, and they are involved in nonviolent criminal acts and drug-assisted rape.[E]

Methamphetamine sellers, unlike other drug dealers, are part of out-of-town organizations. They tend to be older than 30, are very likely to use the drug, and also sell ecstasy.[L,E] They are involved in prostitution and in nonviolent criminal acts, such as theft and burglary.[E]

Diverted OxyContin® is commonly sold by individuals who obtain their own prescriptions legitimately. They tend to be older than 30, and they do not sell other drugs.[L] They are involved in nonviolent criminal acts and in drug-assisted rape.[E]

Diverted alprazolam dealers generally operate independently, are either young adults or older adults, are somewhat likely to use the drug, and are involved in nonviolent crime and drug-assisted rape.[E]

WHERE ARE DRUGS SOLD AND USED?

Heroin and crack markets are generally located in central city areas, powder cocaine markets in both central city and suburban areas, and methamphetamine markets mostly in suburban areas. Marijuana and ecstasy sales are equally distributed among all areas (central city, suburban, and rural).[L]

Most illegal drugs (including heroin, cocaine, marijuana, methamphetamine, and ecstasy) are sold in the following locations:[L,E]

- In streets and open-air markets
- Crack houses/shooting galleries (excluding marijuana and ecstasy)
- Nightclubs and bars (excluding heroin)
- Private residences
- Public housing developments
- Playgrounds and parks
- Private parties
- Hotels/motels

How much do drugs cost?

Drug	Unit	Price
Heroin	1/4 g	$20
	1 g	$80
Powder cocaine	1 g	$50
Crack cocaine	0.1–0.2 g	$20
Marijuana	1/4 oz	$40
	1 oz	$1,100–$1,200
Ecstasy	One tablet	$12–$15
Diverted Oxycontin®	40 mg 80 mg	$20 $40
Hydrocodone	One tablet	$3–$4

Source: Law enforcement respondent

No changes are reported in any price or purity levels between spring and fall 2002.

- Around supermarkets
- Inside cars

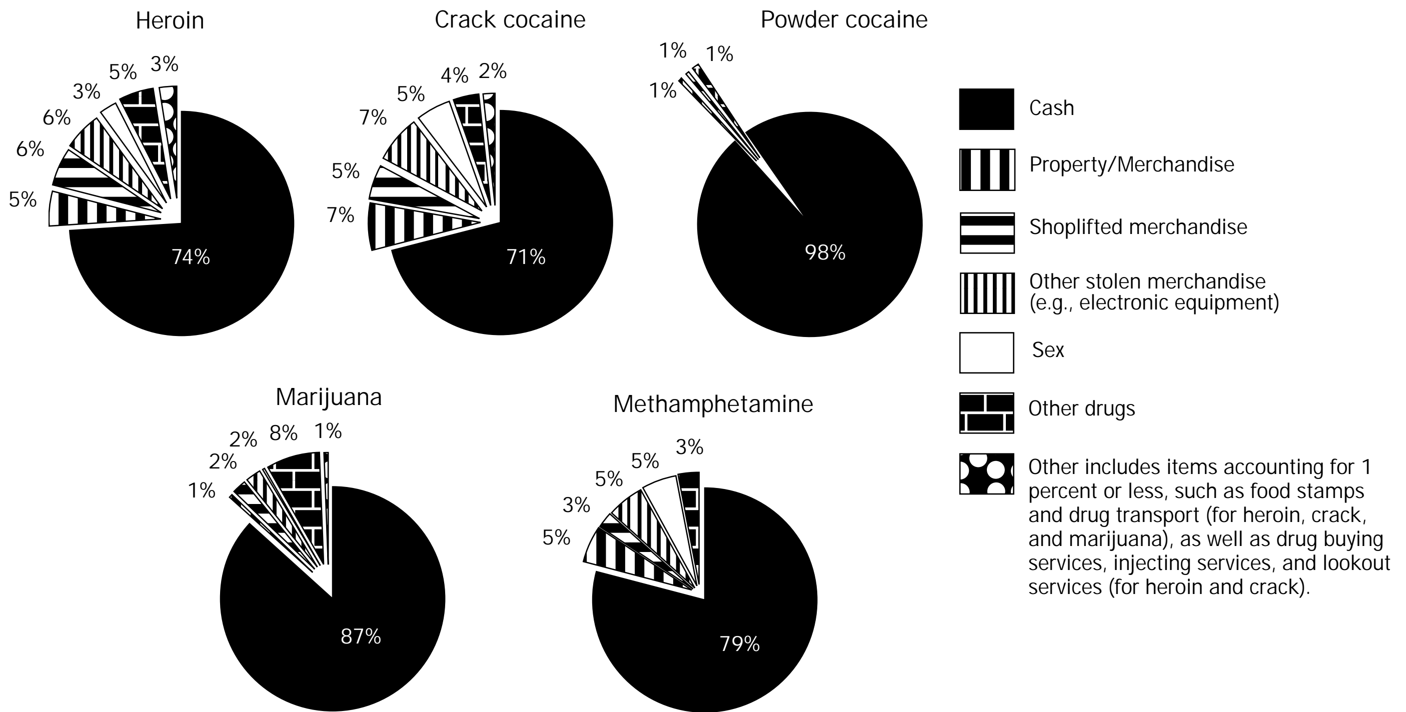
Additional sales settings include the following:[E]

- Around drug treatment clinics: Heroin, crack, marijuana, and ecstasy
- In or around schools: Heroin, marijuana, and ecstasy
- Raves: Heroin, marijuana, methamphetamine, and ecstasy
- College campuses and concerts: Powder cocaine, methamphetamine, and ecstasy
- Shopping malls: Marijuana, methamphetamine, and ecstasy

Diverted OxyContin® is generally sold in the suburbs, inside private residences.[L]

Most use settings mirror sales settings, with the exceptions of playgrounds and parks, around supermarkets, and shopping malls.[E]

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



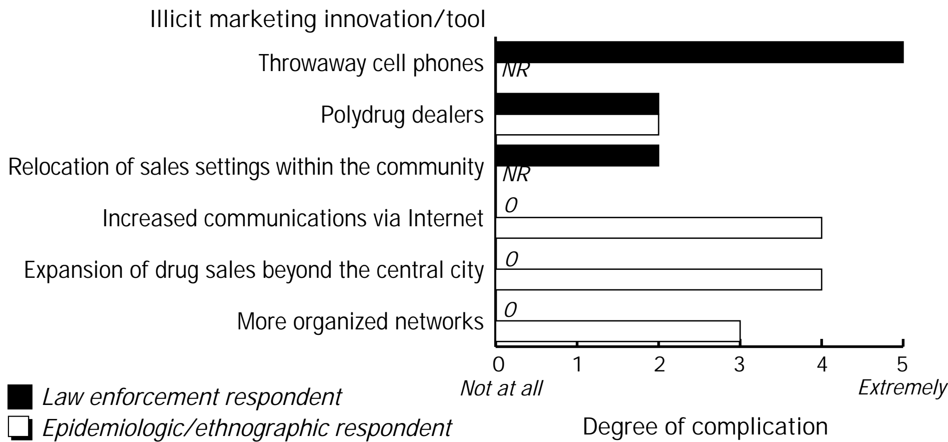
Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents

What they have to say...

- *As in the vast majority of* Pulse Check *cities, most transactions are cash only, particularly in the case of powder cocaine.*
- *The practice of exchanging sex for drugs is less common in Tampa/St. Petersburg than in the majority of other* Pulse Check *cities.*
- *One source notes an increase, over the past decade, in the exchange of diverted prescription drugs—such as alprazolam and OxyContin®—for illicit drugs[E]. Such exchanges are particularly common for methamphetamine[E] and marijuana[M].*

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

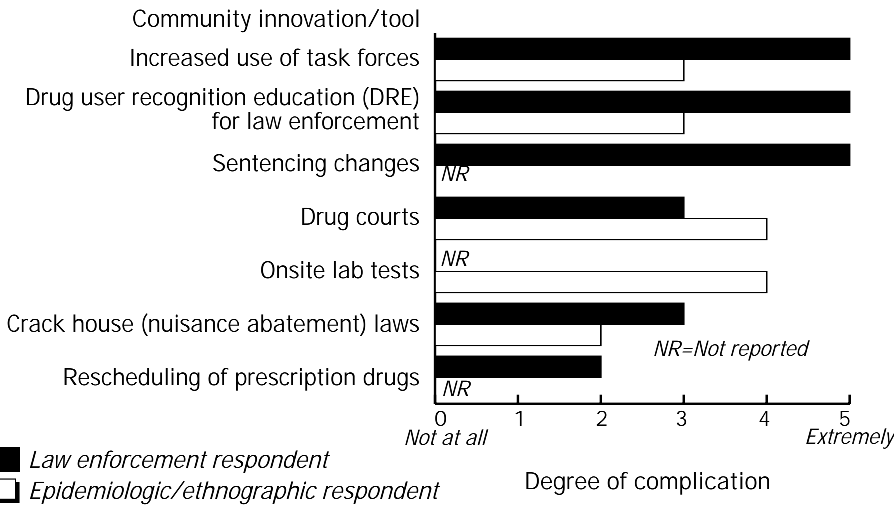
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt drug activity in Tampa/St. Petersburg?



What they have to say...

- *As in the vast majority of* Pulse Check *cities, throwaway cell phones have posed the greatest impediment to detection and disruption efforts.*[L]
- *Most dealers have remained independent, so increased or decreased network organization has not posed as much of a challenge as in other cities.*[L] *Moreover, even though methamphetamine dealers, unlike most other drug dealers, do work within an organized structure, that network has been disrupted by the community's Meth Squad.*[E]
- *Increased communications via the Internet have posed a growing challenge especially among younger users and with regard to gamma hydroxybutyrate (GHB).*

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



What they have to say...

- *Task forces: A Meth Squad has been introduced and has successfully seized many labs in a nearby rural county that serves as the source for Tampa's methamphetamine supply.*[E]
- *Sentencing changes: Minimum mandatory sentences and higher bail for trafficking have proven effective.*[L]
- *DRE: Tampa/St. Petersburg, along with about half of the* Pulse Check *cities, has a DRE program. As in those cities, sources believe it successfully trains law enforcement personnel to recognize drug users.*[L,E]
- *Onsite lab tests: When a needle is found, it can be tested immediately for methamphetamine, enabling quick identification and rapid response.*[E]

SEPTEMBER 11 FOLLOWUP

Except for a staff perception of decreased funding in the non-methadone program,[N] the September 11 attacks and their aftermath have had no continuing aftereffects on the drug abuse situation in Tampa/St. Petersburg.