Special Topic:
Synthetic Opioids

# PULSE CHECK

## Trends in Drug Abuse

### January–June 2001 Reporting Period

Executive Office of the President
Office of National Drug Control Policy
November 2001

# *PULSE CHECK*

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## November 2001

**Executive Office of the President**
**Office of National Drug Control Policy**
**Washington, DC 20503**
**NCJ 191248**

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This issue and previous issues of *Pulse Check* are available online at <www.whitehousedrugpolicy.gov>.

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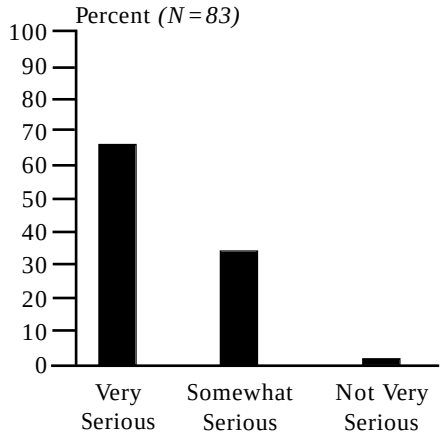
# *PULSE CHECK* HIGHLIGHTS

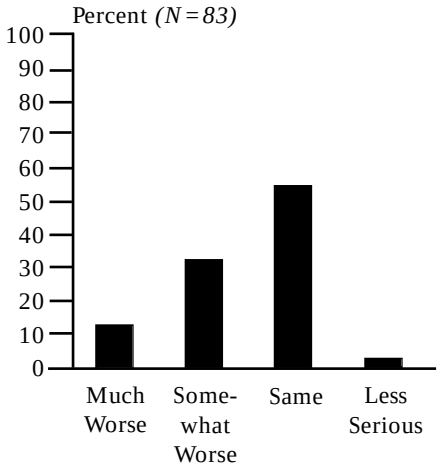
This report is based on discussions with 83 epidemiologists, ethnographers, law enforcement officials, and methadone and non-methadone treatment providers from 21 *Pulse Check* sites. Telephone discussions with these individuals, conducted between May and July 2001, reveal that overall, when comparing spring 2001 with fall 2000, the majority of *Pulse Check* sources consider the drug problem to be very serious but stable. *(Exhibits 1 and 2)*

**Exhibit 1.**
**How serious is the perceived drug problem in the 21 *Pulse Check* communities?**




*Sources: Epidemiologic, ethnographic, treatment, and law enforcement respondents*

**Exhibit 2.**
**How has the perceived drug problem changed (fall 2000 vs spring 2001)?**




*Sources: Epidemiologic, ethnographic, treatment, and law enforcement respondents*

The situation is characterized by several key features:

- Diversion and abuse of OxyContin®, a high-dose formulation of the pharmaceutical opiate oxycodone, is the latest and most rapidly emerging problem. *(Exhibits 3 and 4)*
- Heroin and crack are both equally associated with more serious consequences than any other illicit drugs, as reported in 14 *Pulse Check* sites each. *(Exhibits 5 and 6)*
- Marijuana remains the most widely abused illicit drug, as reported in 19 sites. *(Exhibits 5 and 6)*
- The emerging problem of "ecstasy" (methylenedioxymethamphetamine, or MDMA) and, to a lesser extent, other club drug use continues to intensify. *(Exhibit 4)*
- Methamphetamine continues to be reported as an emerging problem in some areas. *(Exhibit 4)*

## HIGHLIGHTS FROM THE SPECIAL SECTION TOPIC: Synthetic Opiates

*Pulse Check* sources asked about synthetic opiates reported the diversion and abuse of the prescription pain reliever OxyContin® as the emerging drug problem in their sites:

- Nearly all law enforcement sources report increased availability of diverted OxyContin®, with sources in the Northeast generally reporting higher availability than elsewhere.
- Although in most cities OxyContin® abusers are predominantly young adults (18–30 years) or adults (older than 30), adolescent (13–17 years) users are emerging in a few cities, such as Portland (ME) and Miami. Similarly, sources in six cities (in Billings, Boston, Detroit, Miami, Portland, and St. Louis) report OxyContin® abuse specifically among adolescents who have not used opiates previously.
- OxyContin® abuse and diverted sales are emerging in the rave and nightclub scene in Billings, Boston, Miami, New Orleans, Philadelphia, and St. Louis.
- While the media often refer to diverted OxyContin® as "hillbilly heroin," its use is not isolated to rural areas. For example, in Baltimore, Philadelphia, and Washington, DC, abusers reside primarily in central city areas; in Birmingham, Detroit, and Memphis, they reside in rural areas and the suburbs; and in Columbia (SC) and Miami, they reside predominantly in the suburbs.

- Since the last reporting period, OxyContin® diversion has intensified. For example, in Portland (ME), armed robberies of pharmacies for OxyContin® and home invasions of clients who have legitimately filled prescriptions have increased. In Miami, dealers recruit patients from substance abuse treatment facilities, drive them to doctors who prescribe the drug, have the prescriptions filled, then sell the pills illegally.

## HIGHLIGHTS BY SPECIFIC ILLICIT DRUG

The 83 discussions also yielded key findings about heroin, crack cocaine, powder cocaine, marijuana, methamphetamine, and club drugs:

### HEROIN

- Heroin availability remains generally stable at high levels, with only a few increases and no declines reported. High-purity, snortable South American (Colombian) white heroin is the most commonly cited type, followed by lower purity, injectable Mexican black tar, which predominates in the West and in some parts of the South.

- Street-level prices and purity are generally stable—at low and high levels, respectively—with a few exceptions, such as a price drop in El Paso and an increase in Baltimore.

- Young adults (18–30 years) are increasingly using heroin in the majority of *Pulse Check* sites, accor-ding to epidemiologic and ethnographic sources. The number of novice heroin users (any drug treatment client who has recently begun using heroin) has increased in programs across nine *Pulse Check* sites.

- Heroin use is spreading to suburban areas surrounding five *Pulse Check* sites: Baltimore, Memphis, Miami, and Washington, DC, in the South; and Seattle in the West. Use is also spreading to the rural areas surrounding Portland (ME) and El Paso.

- Injecting remains the most common route of heroin administration. Snorting, however, either equals or surpasses injecting in nine *Pulse Check* sites, and it has increased in six sites: Columbia (SC), Denver, El Paso, Miami, New Orleans, Philadelphia, and Washington, DC. New and younger users tend to snort rather than inject.

- "Speedballs" containing heroin plus crack (as opposed to powder cocaine) have increased in El Paso and Los Angeles. Reports of heroin combined with ecstasy have increased in three southern *Pulse Check* sites: Birmingham, Memphis, and Miami.

**Exhibit 3.**
**What new problems have emerged or intensified during spring 2001?**

| OxyContin® | Ecstasy/Club Drugs | Methamphetamine |
|---|---|---|
| Baltimore, MD[E,N] | Baltimore, MD[L] | Columbia, SC[L] |
| Billings, MT[L,N] | Boston, MA[L,N] | Detroit, MI[E] |
| Birmingham, AL[L,N,M] | Columbia, SC[N,M] | El Paso, TX[N] |
| Boston, MA[L,E,M] | Denver, CO[L,E,N] | Memphis, TN[L] |
| Columbia, SC[E] | Detroit, MI[L] | St. Louis, MO[E] |
| Denver, CO[M] | El Paso, TX[E] | Sioux Falls, SD[N] |
| Detroit, MI[E] | Honolulu, HI[L,E,N] | Seattle, WA[L] |
| Miami, FL[L,E,N] | Los Angeles, CA[L,E] | Washington, DC[L] |
| Honolulu, HI[M] | Memphis, TN[E,N] | |
| Philadelphia, PA[L,E,N,M] | New York, NY[E] | |
| Portland, ME[L,E,N] | Philadelphia, PA[N,E] | |
| New Orleans, LA[L,N,M] | Portland, ME[L] | |
| St. Louis, MO[E,M] | Seattle, WA[N] | |
| Washington, DC[E,M] | St. Louis, MO[E] | |
| | Sioux Falls, SD[L,E] | |

**Other Emerging Drug Problems**

Clonidine (Catapres®): Chicago, IL[M]
"Devil's trumpet" herbal: Honolulu, HI[E]
Dextromethorphan (DXM): Washington, DC[E]
Diphenhydramine (Benadryl®): Portland, ME[M]
Hydromorphone (Dilaudid®): Memphis, TN[E]
Marigolds, Khat: Boston, MA[L]
Marijuana + Methamphetamine: Sioux Falls, SD[N]
Marijuana + Cocaine or Heroin: El Paso, TX[M]
PCP: New York, NY[N]
"Red ferrari" (designer amphetamine): Los Angeles, CA[N]
White heroin: Honolulu, HI[E]

*[L]Law enforcement respondents [E]Epidemiologic/ethnographic respondents*
*[N]Non-methadone treatment respondents [M]Methadone treatment respondents*

**Exhibit 4.**
**How has the perceived drug problem changed (fall 2000 vs spring 2001)?**

**Where has the drug with "the most serious consequences" changed?**

| Site/Source | Fall 2000 | Spring 2001 |
|---|---|---|
| El Paso[E] | Heroin | Crack |
| Miami[E] | Heroin | OxyContin® |
| New Orleans[M] | Heroin | OxyContin® |
| Memphis[N] | Crack | Powder cocaine |
| Portland[L] | Powder cocaine | Pharmaceutical opiates |

**Where has "the most commonly abused drug" changed?**

| Site/Source | Fall 2000 | Spring 2001 |
|---|---|---|
| New York[M] | Crack | Heroin |
| Portland[L] | Powder cocaine | Heroin and pharmaceutical opiates |
| Memphis[N] | Powder cocaine | Crack |

*[L]Law enforcement respondents [E]Epidemiologic/ethnographic respondents*
*[N]Non-methadone treatment respondents [M]Methadone treatment respondents*

#### CRACK COCAINE

- Crack remains widely available in the majority of *Pulse Check* sites, with few changes in availability or price. The crack sales scene has remained relatively stable, with only a few isolated changes, including the following:
  - Younger crack sellers are increasingly reported in the South.
  - Electronic equipment, such as cell phones and beepers, continue to be increasingly involved in sales. As a result, sales are moving indoors in some cities, and crack houses are becoming less prominent in others.
  - Gangs have recently started taking over sales in New York.
  - Sales in the Denver area are starting to take place in the suburbs.
- Females are equally or more likely than males to use crack in many cities, more so than any other illicit drug except ecstasy, according to epidemiologic and ethnographic sources.
- While crack is nearly always smoked, increased crack injection is reported in Baltimore and Washington, DC.

#### POWDER COCAINE

- Powder cocaine remains widely available, with few changes in price or purity. El Paso, however, is one exception: powder cocaine and heroin are now cheaper and more abundant on the American side of the border than on the Mexican side.
- Availability and purity levels are particularly high in New York.
- Powder cocaine users often resemble heroin users, rather than crack users. For example, they are more likely to be male, rather than female, and White, rather than Black.
- Young adults and, in some cases, adolescents are increasingly using powder cocaine in five sites: Birmingham, Detroit, Los Angeles, Sioux Falls, and Washington, DC.
- In some sites, such as Washington, DC, powder cocaine use is increasing among White middle socioeconomic suburbanites—sometimes in nightclubs, bars, and private parties.
- Powder cocaine sellers in New York have recently added ecstasy to the many other drugs they sell. In Los Angeles, powder cocaine plus ecstasy is a recent combination.

#### MARIJUANA

- Marijuana availability continues to be wide and stable in nearly every *Pulse Check* site. However, hydroponically grown marijuana availability is increasing in several cities, including Chicago, Miami, St. Louis, and Washington, DC.
- Young adult (18–30 years) user groups are increasing in several cities: Detroit, Los Angeles, and Memphis.
- Compared with heroin, crack, and powder cocaine users, who tend to reside predominantly in central city areas, marijuana users reside in all areas (central, suburban, and rural), reflecting the pervasiveness of marijuana use.
- More than 80 percent of non-methadone treatment sources report that marijuana users are referred to treatment by the criminal justice system, an increase from the last reporting period. Criminal justice referrals involving heroin and crack have also increased dramatically. The next *Pulse Check* will continue to monitor this trend.

#### METHAMPHETAMINE

- Methamphetamine continues to be more widely available in the West than in other U.S. regions. Moreover, half of western sources report increasing availability.

- Methamphetamine is considered the most widely used drug in two western *Pulse Check* cities: Billings and Honolulu. It is reported as the drug contributing to the most serious consequences by 13 sources in 4 cities: Billings, Denver, Honolulu, and Sioux Falls.

- Most sources link methamphetamine sellers to domestic violence, much more so than any other illicit drug sellers.

### CLUB DRUGS

- Ecstasy continues to be the most available club drug (more than 90 percent of law enforcement, epidemiologic, and ethnographic sources report it as widely or somewhat available), followed by gamma hydroxybutyrate (GHB), ketamine, and flunitrazepam (Rohypnol). Ecstasy availability continues to increase in most sites, while GHB, ketamine, and Rohypnol availability is stable.

- Ecstasy is reported as an emerging drug of abuse in 15 sites.

- Ecstasy seller and user populations continue to expand to include various ethnic sellers in the Northeast, Black sellers in the South, adolescent users across the country, and non-White and Hispanic users in some southern and western cities. Ecstasy sale and use settings also continue to expand from raves, concerts, nightclubs, and bars to streets, private residences, and private parties.

- Drugs sold and used with ecstasy are expanding from marijuana and other club drugs to heroin and powder and crack cocaine.

**Exhibit 5.**
**What are the most serious drug problems in the 21 *Pulse Check* sites, by type of source?***

| | City | Most commonly abused?* | | | Most serious consequences? | | | |
|---|---|---|---|---|---|---|---|---|
| | | L | E | N | L | E | N | M |
| Northeast | Boston, MA | HCl | MJ | H | Crack | Crack | H | Cocaine + Alcohol |
| | New York, NY | MJ | MJ | Crack | H | Crack | Crack | Crack |
| | Philadelphia, PA | MJ | MJ | H | H | H | H + Crack | H |
| | Portland, ME | H/Pharm. Opiates | MJ | Crack | Pharm. opiates | H | H | Benzos |
| South | Baltimore, MD | H | H | Crack | H | H | Crack + H | NR |
| | Birmingham, AL | Crack | MJ | Crack | Crack | Crack | Crack | Any IV drugs |
| | Columbia, SC | MJ | Crack | MJ | Crack | Crack | Alcohol | H |
| | El Paso, TX | MJ | MJ | Crack | NR | Crack | H | H |
| | Memphis, TN | Crack | MJ | MJ | Crack | Crack | HCl | NR |
| | Miami, FL | Crack | MJ | Crack | Crack | Oxy | Crack | NR |
| | New Orleans, LA | MJ | Crack | Crack | Crack | Crack | Crack | Oxy |
| | Washington, DC | Crack | Cocaine | Crack | MJ | H | Crack | H |
| Midwest | Chicago, IL | Crack | MJ | Crack | Crack | Crack | Crack | H |
| | Detroit, MI | MJ | MJ | Crack | Crack | H | Crack | H |
| | St. Louis, MO | MJ | MJ | NR | Crack | Crack | Crack | H |
| | Sioux Falls, SD | MJ | MJ | MJ | Meth | Meth | Meth | Meth |
| West | Billings, MT | Meth | MJ | Alcohol | Meth | Meth | Meth | NR |
| | Denver, CO | MJ | MJ | Crack + HCl | HCl | HCl | Meth | MJ |
| | Honolulu, HI | MJ | Meth | MJ | Meth | Meth | Meth | Benzos + Meth |
| | Los Angeles, CA | Crack | MJ | MJ | Crack | H | Meth | H |
| | Seattle, WA | MJ | H | MJ | H | H | Cocaine | Benzos |

**Heroin is almost always, by definition, the most commonly used drug in methadone programs, so methadone treatment sources are excluded from this question.*
*Note: HCl = Powder cocaine; MJ = Marijuana; H = Heroin; Meth = Methamphetamine; Benzos = Benzodiazepines; Oxy = OxyContin®*
*[L]Law enforcement respondents [E]Epidemiologic/ethnographic respondents*
*[N]Non-methadone treatment respondents [M]Methadone treatment respondents*

**Exhibit 6.**
**What are the most serious drug problems in the 21 *Pulse Check* sites, by number of sources and sites?**

| Drug | Most commonly abused?* | | Most serious consequences? | |
|---|---|---|---|---|
| | No. of sources | No. of sites | No. of sources | No. of sites |
| Heroin | 6 | 5 | 24 | 14 |
| Crack | 20 | 14 | 29 | 14 |
| Powder cocaine | 1 | 1 | 2 | 1 |
| Marijuana | 30 | 19 | 1 | 1 |
| Methamphetamine | 3 | 2 | 13 | 4 |
| Pharmaceutical opiates | 1 | 1 | 3 | 3 |
| Benzodiazepines | 1 | 1 | 3 | 3 |
| Alcohol | 2 | 2 | 2 | 2 |

**Methadone treatment sources are excluded from this count.*
*Sources: Law enforcement, epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents*

## INTRODUCTION

Since 1992, the Office of National Drug Control Policy (ONDCP) has published the *Pulse Check*, a source for timely information on drug abuse and drug markets. The report aims to describe hardcore drug-abusing populations, emerging drugs, new routes of administration, varying use patterns, changing demand for treatment, drug-related criminal activity, and shifts in supply and distribution patterns. *Pulse Check* regularly addresses five drugs of serious concern: cocaine, marijuana, heroin, methamphetamine, and—as of the last issue—"ecstasy" (methylenedioxymethamphetamine, or MDMA) and other club drugs. Additionally, the current issue provides information on an emerging problem: diversion and abuse of OxyContin®, a high-dose formulation of the pharmaceutical opiate oxycodone.

The *Pulse Check* is not designed to be used as a law enforcement tool but rather to be a research report presenting findings on drug use patterns and drug markets as reported by ethnographers, epidemiologists, treatment providers, and law enforcement officials. With regards to race and ethnicity, just as the National Household Survey on Drug Abuse and other national data sources report findings by race and ethnicity, sources contributing to the *Pulse Check* are asked to describe the age, ethnicity, and gender of illegal drug users and those who sell drugs and any changes in these characteristics. The information provided to *Pulse Check* reflects the observations of the sources, and their descriptions are purely for determining the size, scope, and diversity of the drug problem. The intent of the *Pulse Check* has been and continues to be merely to describe patterns in illicit drug use and illicit drug markets that are emerging in local communities.

**The 21 *Pulse Check* Sites**


### Enhancements to *Pulse Check*

The current *Pulse Check* issue includes two changes over the previous issue, reflecting ONDCP's ongoing effort to enhance the project and keep up with the changing nature of the Nation's drug abuse situation. First, due to particular concerns about the drug abuse situation in Baltimore, MD, that city was added to the list of *Pulse Check* sites, bringing the total to 21 geographically diverse cities—highlighted on the map above—spread across the four Census regions and representing both rural and urban areas. Second, to ensure regular reporting, any treatment provider who was unavailable to participate was replaced via purposeful selection, in consultation with experts in the field, rather than the random selection that was used in the past.

### Use and Interpretation of *Pulse Check* Information

By contacting professionals from three different disciplines—ethnography/epidemiology, law enforcement, and treatment—a rich picture of the changing drug abuse situation emerges. Though this approach offers substantial strengths in timeliness and depth, *Pulse Check* is not a measure of the prevalence of drug abuse or its consequences. As an anecdotal source of information, any interpretation or conclusion drawn from *Pulse Check* must be viewed carefully and in conjunction with other more quantifiable direct and indirect measures of the drug abuse problem.

More specifically, several of the limitations of *Pulse Check* are briefly discussed below.

- *Pulse Check* is limited to a report on the drug abuse situation in 21 specific sites throughout the Nation. Though considerable effort was made to select sites across a broad range of geographic areas, including Census regions

and divisions, urban and rural States, racial/ethnic coverage, and high intensity drug trafficking areas, *Pulse Check* cannot be viewed as a national study, and information cannot be reasonably aggregated up to a national level.

- Of the 85 sources identified and recruited across the three disciplines, 83 provided information for this *Pulse Check* issue. The information presented in this report is based solely on the observations and perceptions of those 83 individuals. These individuals may not be knowledgeable about every aspect of the drug abuse situation in their sites, and they may have biases based on their experiences and exposures.
- Due to the comprehensive nature of the telephone discussions, sources were asked to discuss only areas in which they were thoroughly knowledgeable. Thus, the total number (*N*) of respondents to any one question might be less than 83.

Any contradictory reports within an individual site are not necessarily a *Pulse Check* limitation. Just as the site sampling methodology was designed to reflect the country's geographic and population diversity, recruiting four sources per site was incorporated into the design to reflect diversity within each of the 21 sites. For example, a law enforcement source in one site might perceive cocaine to be the community's most serious problem, while an ethnographic source at that same site might consider the most serious problem to be heroin. And they would both be right—because each might come in contact with different populations or each might deal with a specific geographic neighborhood.

Information from treatment sources is particularly susceptible to variance because some facilities target specific populations. Furthermore, treatment providers from methadone and non-methadone programs are likely to have very different perspectives on their communities' drug problems because their respective clientele differ in the nature of their drug problems and in their demographic characteristics. It is for this reason that two treatment sources were selected from each of the 21 sites—one from a methadone program, and one from a non-methadone program. Taken together, all four sources at each site provide a richer picture of the drug problem's nature.

### Current Sources and Reporting Periods

The current report includes information gathered during May through July 2001 from telephone conversations with 83 sources, representing 21 sites across the various regions of the country. These individuals discussed their perceptions of the drug abuse situation as it was during the spring months of 2001 and in comparison to a period 6 months earlier, during fall 2000.

The law enforcement sources who provided information include 21 narcotics officers from local police departments, field office agents of the Drug Enforcement Administration (DEA), and representatives of High Intensity Drug Trafficking Areas (HIDTAs). The epidemiologists and ethnographers are 21 researchers associated either with local health departments, university-based research groups, or other community health organizations. Some of those 21 individuals are qualitative researchers who employ ethnographic techniques to obtain observational data directly from the drug user's world; others are epidemiologists who access both qualitative and quantitative data. The treatment sources are 41 providers from 23 non-methadone programs and 18 methadone programs across the 21 sites. Those providers include two non-methadone sources each from Billings and Sioux Falls because those cities do not have methadone programs. They also include two methadone sources from Boston, both of whom were available to contribute information. They do not include two methadone sources from Baltimore and Memphis, who were unable to participate in this round of discussions.

These sources offer a wealth of information that, when taken together, provides a comprehensive snapshot of drug abuse patterns in communities across the country. Further, these individuals provide expertise that can alert policy makers to any short-term changes or newly emerging problems concerning specific drugs, drug users, and drug sellers.

The appendices at the end of this report provide a list of these sources, describe the methodology used to select them, and discuss the content of the approximately 1-hour conversations held with them.

# TRENDS IN DRUG USE: FALL 2000 VS SPRING 2001

## HEROIN: THE PERCEPTION

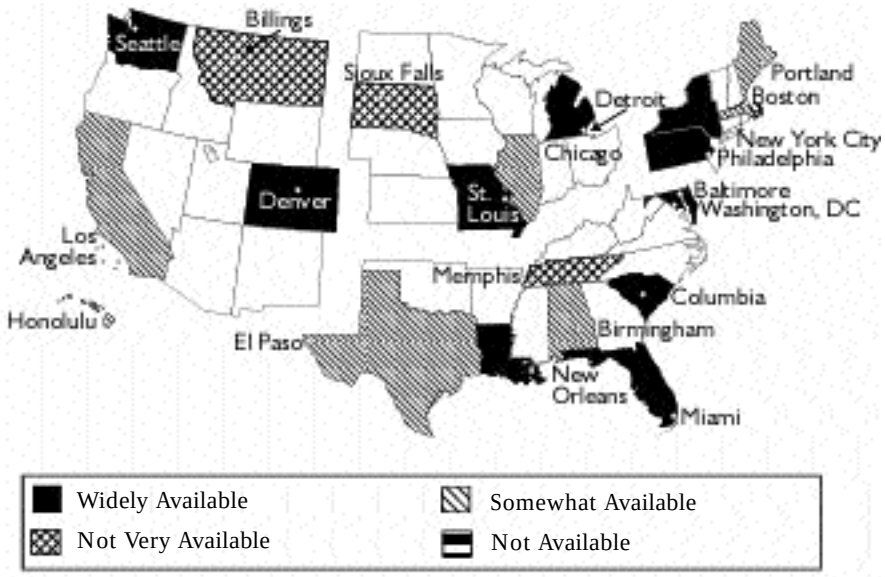
How do *Pulse Check* sources perceive the heroin problem in their communities? Excluding sources associated with methadone programs, where heroin is by definition the most commonly used drug, only six sources in five cities consider heroin as their communities' most commonly used illicit drug: the ethnographic and law enforcement sources in Baltimore, the non-methadone treatment sources in Boston and Philadelphia, the epidemiologic source in Seattle, and the law enforcement source in Portland, ME (who also lists pharmaceutical opiates as an equally serious problem).

Additionally, sources in 10 cities consider heroin the second most commonly used illicit drug in their communities. They span the country, ranging from the Northeast (New York, Philadelphia, and Portland) to the South (Baltimore, El Paso, and Washington, DC) to the Midwest (Chicago), and the West (Honolulu, Los Angeles, and Seattle).

The numbers go up somewhat when discussing which drug has the most serious consequences—that is, medically, legally, societally, or otherwise. Heroin is named by 24 sources (of 82 who discussed this question) in 14 cities: all *Pulse Check* cities in the Northeast (Boston, New York, Philadelphia, Portland), as well as cities in the South (Baltimore, Columbia (SC), El Paso, and Washington, DC), the Midwest (Chicago, Detroit, and St. Louis), and the West (Denver, Los Angeles, and Seattle). In the case of Philadelphia, all *Pulse Check* sources agree that heroin is the drug with the most serious consequences. An additional 22 sources name heroin as the second most serious drug in terms of consequences to 11 *Pulse Check* communities.

**Exhibit 1.**
**How available is heroin across the 21 *Pulse Check* cities?**

*According to law enforcement sources (N = 21)...*




*According to epidemiologic and ethnographic sources (N = 20)...**


**The epidemiologic source in Columbia, SC, did not provide this information.*

In many cases, the perception of a community's drug abuse picture changes radically when distinguishing a city from its surrounding environs. In Seattle, for example, the epidemiologic source considers heroin and crack, respectively, to be the city's first and second most commonly abused drugs; in the surrounding rural areas, however, methamphetamine and marijuana hold those distinctions.

Has the perception of the heroin problem changed between fall 2000 and spring 2001? All but two of the *Pulse Check* sources who name heroin as the most commonly used illicit drug during the current reporting period also listed it as such during the previous period. The two exceptions occur in New York and Portland. According to the New York methadone treatment source, heroin has replaced crack as the most commonly used illicit drug, while the Portland law enforcement source states that it has replaced powder cocaine among hardcore users.

Three sources perceive that other drugs have replaced heroin as causing the most serious consequences. Crack has replaced heroin in El Paso, according to that city's epidemiologic source. And the diversion and abuse of the pharmaceutical opiate oxycodone (in its OxyContin® formulation) has replaced heroin in Miami and New Orleans, according to those cities' epidemiologic and methadone treatment sources, respectively.

Only one *Pulse Check* source considers heroin to be a new or emerging drug problem in comparison to the last *Pulse Check* reporting period: the Denver epidemiologic source, who notes an increase in suburban young White heroin users.

## HEROIN: THE DRUG

How available is heroin across the country? *(Exhibit 1)* Approximately half of the *Pulse Check* law enforcement sources (11 of 21) consider heroin to be widely available in their communities: New York and Philadelphia in the Northeast; Baltimore, Columbia (SC), Miami, New Orleans, and Washington, DC, in the South; Detroit and St. Louis in the Midwest; and Denver and Seattle in the West. Similarly, the majority of epidemiologic and ethnographic sources who discussed this question (12 of 20) consider the drug widely available: New York, Philadelphia, and Portland in the Northeast; Baltimore, El Paso, New Orleans, and Washington, DC, in the South; Chicago and Detroit in the Midwest; and Denver, Honolulu, and Seattle in the West. Heroin is cited as not very available by only five sources in four cities (Billings, Birmingham, Memphis, and Sioux Falls), and only one source considers it not available at all (the law enforcement source in Sioux Falls). The remaining 12 sources describe the drug as "somewhat available."

**Exhibit 2.**
**How has heroin availability changed (fall 2000 vs spring 2001)?***

**Birmingham, AL[L]**
**Denver, CO[E]**
**El Paso, TX[E]**
**Memphis, TN[E]**
**Miami, FL[E]**
**New Orleans, LA[E]**
**Portland, ME[L,E]**
**Washington, DC[L]**

| | |
|---|---|
| **Baltimore, MD[L,E]** | **Los Angeles, CA[E]** |
| **Billings, MT[L,E]** | **Memphis, TN[L]** |
| **Birmingham, AL[E]** | **Miami, FL[L]** |
| **Boston, MA[L, E]** | **New Orleans, LA[L]** |
| **Chicago, IL[L,E]** | **New York, NY[L,E]** |
| **Columbia, SC[L]** | **Philadelphia, PA[L,E]** |
| **Denver, CO[L]** | **Seattle, WA[L,E]** |
| **Detroit, MI[L,E]** | **Sioux Falls, SD[L,E]** |
| **El Paso, TX[L]** | **St. Louis, MO[L,E]** |
| **Honolulu, HI[L,E]** | **Washington, DC[E]** |

*[L] Law enforcement respondents*
*[E] Epidemiologic/ethnographic respondents*
**The Columbia epidemiologic source did not provide this information.*

Has heroin availability changed? *(Exhibits 2 and 3)* Heroin availability remained stable between fall 2000 and spring 2001, according to the majority (18 of 21) of *Pulse Check* law enforcement sources. Increased availability is perceived in only three sites: Portland (ME) in the Northeast; and Birmingham and Washington, DC, in the South. No declines are reported. According to the 20 epidemiologic and ethnographic sources who discussed this question, heroin availability increased in 6 sites: El Paso, Memphis, Miami, and New Orleans in the South; Portland in the Northeast; and Denver in the West. The remaining 14 epidemiologic and ethnographic sources perceive stable supplies of heroin in general, but some of those 14 report increases in specific forms of heroin. In Detroit, for example, Southeast and Southwest Asian heroin availability appears up. Los Angeles is another example, with an increase reported in availability of Mexican black tar and brown heroin. A third example is Honolulu, where the predominant Mexican black tar has increased in availability, but where a white powder heroin has also been seized for the first time.

### Traffic in reverse?

According to the El Paso epidemiologic source, heroin is now cheaper and more abundant on the American side of the border than on the Mexican side–to the point where people from Mexico are crossing over to buy heroin in El Paso. These changes are attributed to competition for the market by three different cartels. El Paso's law enforcement source, on the other hand, gives heroin only a "somewhat available" rating.

**Exhibit 3. How available are the different varieties of heroin? How has their availability changed (fall 2000 vs spring 2001)?***

| | City | All forms | | Colombian | | Mexican black tar | | Mexican brown | | SEA** | | SWA*** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | L | E | L | E | L | E | L | E | L | E | L | E |
| Northeast | Boston, MA | ◗↔ | ◗↔ | ◗↔ | NR | ○↔ | NR | ○↔ | NR | ☽↔ | NR | ○↔ | NR |
| | New York, NY | ●↔ | ●↔ | ●↔ | ●↔ | ○↔ | ☽↓ | ○↔ | ☽↓ | ●↔ | ☽↔ | ◗↔ | ☽↓ |
| | Philadelphia, PA | ●↔ | ●↔ | ●↔ | ●↔ | ☽↔ | ○↔ | ☽↔ | ○↔ | ☽↔ | ○↔ | ☽↔ | ○↔ |
| | Portland, ME | ◗↑ | ●↑ | ◗↑ | | ☽↑ | ○ | ☽↑ | ○ | ◗↑ | NR | ◗↑ | ●↑ |
| South | Baltimore, MD | ●↔ | ●↔ | ●↔ | ●↔ | ☽↔ | ● | ☽↔ | ☽ | ◗↔ | NR | ☽↔ | NR |
| | Birmingham, AL** | ◗↑ | ☽↔ | NR | NR | NR | NR | NR | NR | NR | NR | NR | NR |
| | Columbia, SC | ●↔ | NR | ●↔ | NR | ◗↔ | NR | ◗↔ | NR | ◗↔ | NR | ◗↔ | NR |
| | El Paso, TX | ◗↔ | ●↑ | ○↔ | ○ | ◗↔ | ●↓ | ◗↔ | ●↓ | ○↔ | ○ | ○↔ | ○ |
| | Memphis, TN | ☽↔ | ◗↑ | ○↔ | ◗ | ◗↔ | ● | ◗↔ | NR | ◗↔ | NR | ○↔ | NR |
| | Miami, FL | ●↔ | ◗↑ | ●↔ | ●↑ | ○↔ | ☽↔ | ○↔ | ☽↔ | ○↔ | ☽↔ | ○↔ | ☽↔ |
| | New Orleans, LA | ●↔ | ●↑ | ●↔ | ◗↔ | ☽↔ | ☽↔ | ☽↔ | ☽↔ | ☽↔ | ◗↔ | ☽↔ | ◗↔ |
| | Washington, DC | ●↑ | ●↔ | ●↑ | ◗ | ○ | NR | ○ | ☽ | ●↑ | NR | ◗↑ | NR |
| Midwest | Chicago, IL | ◗↔ | ●↔ | ◗↑ | ●↔ | ☽↓ | ◗↔ | ☽↔ | ●↔ | ◗↔ | ●↔ | ☽↓ | ●↔ |
| | Detroit, MI | ●↔ | ●↔ | ●↔ | ●↔ | ☽↔ | ☽↔ | ☽↔ | ☽↔ | ◗↔ | ◗↑ | ◗↔ | ◗↑ |
| | St. Louis, MO | ●↔ | ◗↔ | ◗↔ | ○↔ | ●↔ | ◗↔ | ●↔ | NR | ○↔ | ○↔ | ○↔ | ☽↔ |
| | Sioux Falls, SD | ○↔ | ☽↔ | ○↔ | NR | ○↔ | | ○↔ | NR | ○↔ | NR | ○↔ | NR |
| West | Billings, MT | ☽↔ | ☽↔ | ○↔ | ☽↔ | ☽↔ | ☽↔ | ○↔ | ☽↔ | ○↔ | ☽↔ | ○↔ | ☽↔ |
| | Denver, CO | ●↔ | ●↑ | ◗↔ | ○ | ●↔ | ●↔ | ●↔ | ◗↑ | ○↔ | ○ | ●↔ | ○ |
| | Honolulu, HI | ◗↔ | ● | ○↔ | NR | ●↑ | ●↔ | ◗↑ | NR | ◗↔ | NR | ○↔ | NR |
| | Los Angeles, CA | ◗↔ | ◗↔ | ☽↑ | ◗↔ | ●↑ | ●↑ | ◗↔ | ●↑ | ◗↔ | ☽↔ | ◗↔ | ☽↔ |
| | Seattle, WA | ●↔ | ●↔ | ☽↔ | ○ | ●↔ | NR | ☽↔ | NR | ☽↔ | ○ | ☽↔ | ○ |

*Sources: Law enforcement (L) and epidemiologic/ethnographic (E) respondents*
● *Widely available* ◗ *Somewhat available* ☽ *Not very available* ○ *Not available*
** Arrows indicate up, down, or stable trends. Absence of an arrow indicates that respondent did not provide trend information.*
***Southeast Asian ***Southwest Asian*

What kind of heroin is available across the country? *(Exhibit 3)* As in the last *Pulse Check* report, South American (Colombian) white heroin is the most common type, cited as widely available by sources in nine cities across all the regions except the West and as somewhat available by sources in six cities–again, spanning the Northeast, South, and Midwest regions. By contrast, this high-purity, snortable heroin is described as "not very available" or "not available" by sources in 11 cities: Portland in the Northeast; Birmingham, El Paso, and Memphis in the South; Sioux Falls and St. Louis in the Midwest; and Billings, Denver, Honolulu, Los Angeles, and Seattle in the West. Since the last *Pulse Check* reporting period, availability of Colombian heroin has increased in only five cities, spanning all four regions: Chicago, Los Angeles, Miami, Portland (ME), and Washington, DC. Stable trends are reported in all other *Pulse Check* cities.

Mexican black tar, a lower purity, injectable heroin, is ranked as widely available by sources in eight cities, mostly in the West and the South (and in St. Louis in the Midwest). Sources in five cities consider it somewhat available, and sources in nine cities consider it not very available. It is described as "not available at all" by sources in seven cities: all four northeastern *Pulse Check* cities; Miami and Washington, DC, in the South; and Sioux Falls in the Midwest. Since the last *Pulse Check* reporting period, black tar has become increasingly available in Honolulu, Los Angeles, and Portland (ME). Availability has declined in Chicago and (slightly) in El Paso. Stable trends are reported elsewhere. Southeast Asian and Southwest Asian heroin are the least common forms, with wide availability reported in only three cities apiece and increased availability reported only in Detroit, Portland, and Washington, DC.

### White heroin hits St. Louis?

According to the St. Louis epidemiologic source, that city's supply is almost exclusively Mexican black tar. However, a recent seizure involved a white heroin whose signature has not yet been established but is suspected to be of Nigerian origin.

How pure is heroin across the country? *(Exhibit 4)* According to law enforcement, epidemiologic, and ethnographic sources, street-level Colombian heroin purity ranges from as low as 7 percent in New Orleans to as high as 95 percent in Philadelphia. Typically, however, purity is at the higher end of that range. Street-level Mexican black tar heroin purity ranges from 14 to 58 percent, with both extremes reported in Seattle. Users often tend to complain about low purity despite evidence to the contrary. As the New York ethnographic source notes, "We continue to hear users complain about the 'bad dope,' when everybody is saying that there has never been such 'good dope' around." That source adds, however, that in this case the users' perceptions might be accurate, because "high availability and low prices are making it possible for street dealers to dilute the heroin."

Then and Now: Heroin purity (fall 2000 vs spring 2001)

*Heroin purity remained relatively stable in the majority of* Pulse Check *sites, according to law enforcement, epidemiologic, and ethnographic sources. Levels increased in only four cities (Honolulu, Miami, New Orleans, and Washington, DC) and declined in only one (Denver). None of these changes appears particularly dramatic.*

What adulterants are added to heroin? A wide range of heroin adulterants, some benign and some harmful, are reported by law enforcement, epidemiologic, and ethnographic sources in several cities, particularly in the Northeast and South: "any powder" in Portland; lactose in Boston; rat poison, powdered milk, baking soda, and coffee creamer in New York; quinine and sugar in Baltimore; scopolamine and baby powder in Columbia (SC); cocaine and vitamin $B_{12}$ in Memphis; baking soda and "any white powder" in Miami (the same adulterants as in cocaine, but one shade darker); baby laxatives and powder in Detroit; and sugar in Los Angeles (to give black tar a tan appearance).

"Tres pesos" and "benita"...

**New York, NY:** According to the ethnographic source, "A user in Brooklyn stated that the heroin was being mixed with 'Tres Pesos' (meaning 'three steps'), which is a rat poison shipped from Santo Domingo. (They call it three steps because after the mice inhale it they take three steps and die.) The user said the reaction is intense, the rush is quicker, and they feel like they're going to die."

**Baltimore, MD:** The ethnographic source reports that "'benita,' a type of heroin cut with quinine, which has been around for a while, is less available than before."

What are street-level heroin prices across the country? *(Exhibit 4)* The most commonly reported heroin street sales unit is 0.1 gram, which sells for as little as $4 for Colombian heroin in Boston to as much as $120 for Mexican black tar in Seattle. In some cities, however, street sales units are much larger: for example, the Birmingham law enforcement source states that "no one wants to sell less than 1 gram" of heroin. Purity, sales quantity, and dealer competition all play a part in determining heroin price. Sometimes, however, other more subtle factors—such as marketing strategies or barter—come into play. For example, according to the New York ethnographic source, "Some dealers in the Bronx and Brooklyn have been offering a $5 bag to lure customers." Another example is Hawaii, where the epidemiologic source notes that few people buy drugs for cash. Rather, they tend to barter goods, services, or other drugs. Many of the goods, such as stereos, cameras, and jewelry, are obtained via larceny and other forms of theft.

Then and Now: Heroin prices (fall 2000 vs spring 2001)

*Heroin prices appear to be relatively stable, according to the majority of law enforcement, epidemiologic, and ethnographic sources who provided this information. Prices increased in only four cities (Baltimore, Chicago, New Orleans, and Washington, DC) and declined in only three (El Paso, Los Angeles, and St. Louis).*

Three of the reported price increases are in the South. In New Orleans, cellophane bags containing two or three doses of white heroin increased both in price and purity. Capsules (known on the street as "pills") are the most common street sales unit in Baltimore, where prices increased from $3–$6 to $10 for a pill of equal (but unknown) size while purity remained stable. In nearby Washington, DC, the milligram price increased from $1.13 to $1.36. In the Midwest, a slight increase is reported in the price of a medium- to large-sized bag of heroin (from $10 to $10–$20) in Chicago.

The El Paso price drop is dramatic, from $10 to $3 per "hit" (amount not specified), reflecting the increased availability and cartel competition described above. Also reflecting increased availability, black tar prices in Los Angeles declined sharply at the hit (0.25 gram) level (from $35–$100 to $20–$40), at the gram level (from $150–$300 to $100), and at the "eightball" (1/8 ounce) level (from $400–$600 to $300). The St. Louis price drop involves "bindles" of #6 gel caps, which sold for the "low 20s" in fall 2000 and the "high teens" in spring 2001.

How is heroin referred to across the country? *(Exhibit 5)* Street names throughout the country often vary by geographic region and by type of heroin. However, some terms, such as "horse," "H," and "boy" are common across regions. Street names (slang) and brand names (dealer designations) are often interchangeable, as is the case in New York ("millennium 2000") and Washington, DC ("jerry springer" and "747" ). Many factors other than brand names, however, can engender a street name. In Washington, DC, for example, the non-methadone source reports that a major news event, such as a hurricane or tornado, can trigger a new street name.

**Exhibit 4. What are the prices and purity levels of different types of heroin in 18 *Pulse Check* cities?* How have prices and purity changed (fall 2000 vs spring 2001)?**

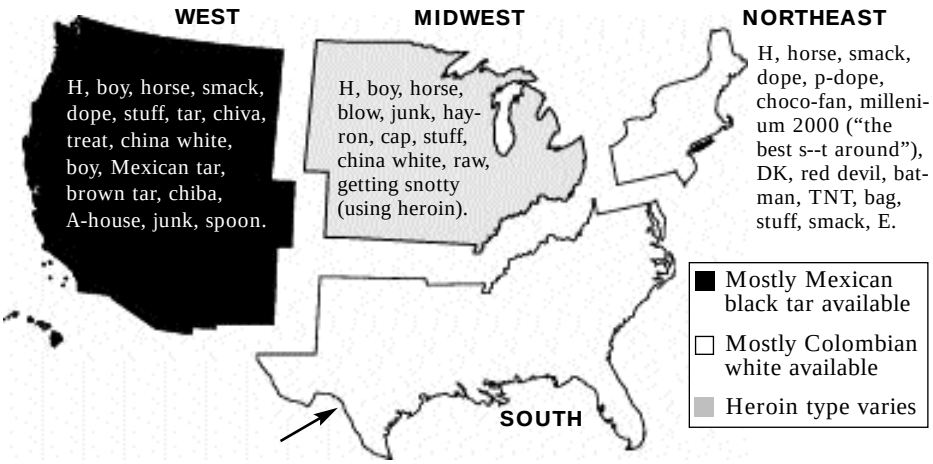
| | City | Source | Unit | Size | Price/*Change*** | | Purity/*Change*** | |
|---|---|---|---|---|---|---|---|---|
| South American (Colombian) white | Baltimore, MD | E | pill | NR | $10 | ↑ | NR | ↔ |
| | Boston, MA | L | "bundle" | 0.1 gm | $4–$6 | ↔ | 60–70% | ↔ |
| | Chicago, IL | L | "hit" | 0.2 gm | $20 | ↔ | NR | NR |
| | Columbia, SC | L | "bindle" | 0.2 gm | $20–$25 | ↔ | 62% | ↔ |
| | | L | "bundle" | 2 gm | $225 | ↔ | NR | NR |
| | Detroit, MI | L | "bindle" | 1 gm | $125–$175 | ↔ | 50% | ↔ |
| | | L | "pack" | 2 dosage units | $10–$20 | ↔ | NR | NR |
| | Miami, FL | E | "bag" | 0.1 gm | $10 | ↔ | 20% | ↑ |
| | New Orleans, LA | L | "unit" | 0.45 gm | $20–$25 | ↑ | 7% | ↔ |
| | New York, NY | L | "hit" | NR | $10–$14 | ↔ | 80–90% | ↔ |
| | | L | "bundle" | 10 bags | $95–$107 | ↔ | 80–90% | ↔ |
| | | L | NR | 1 gm | $60–$74 | ↔ | 80–90% | ↔ |
| | | L | NR | 1 oz | $2,000 | ↔ | 80–90% | ↔ |
| | Philadelphia, PA | L | "baggie" | NR | $10–$20 | ↔ | 40–95% | ↔ |
| | | E | "hit" | NR | $10 | ↔ | NR | NR |
| | | L | "bundle" | (10–13 bags) | $100 | ↔ | 40% | ↔ |
| Mexican black tar | Denver, CO | L | "balloon" | 0.2 gm | $20 | ↔ | 20–30% | ↓ |
| | El Paso, TX | L | NR | 0.1 gm | $20 | ↔ | NR | NR |
| | | E | "hit" | NR | $3 | ↓ | NR | ↔ |
| | Honolulu, HI | L | "bindle" | 0.1 gm | $50–$75 | ↔ | NR | NR |
| | Los Angeles, CA | L | "hit" | 0.25 gm | $20–$40 | ↓ | 25% | ↔ |
| | | L | "eightball" | 1/8 oz | $300 | ↓ | 25% | ↔ |
| | | L | NR | 1 gm | $100 | ↓ | 20% | ↔ |
| | St. Louis, MO | E | #6 gel cap-"bindle" | 0.25–0.5 gm | "high teens" | ↓ | NR | NR |
| | Seattle, WA | E | "bindle" | NR | $20 | ↔ | 20–25% | ↔ |
| | | L | NR | 0.1 gm | $90–$120 | NR | 14–58% | ↔ |
| | | E | NR | 1 gm | $80 | ↔ | 20–25% | NR |
| | | L | NR | 1 oz | $600–$1,300 | NR | 14–58% | ↔ |
| Southeast Asian | Memphis, TN | L | "pack" | 0.1 gm | $30 | ↔ | 40–50% | ↔ |
| | | E | NR | 1 gm | $125–$175 | NR | NR | NR |
| | | E | "hit" | square inch bag | $125–$175 | NR | NR | NR |
| Unspecified | Birmingham, AL | L | (powder) | 1 gm | $500 | NR | NR | NR |
| | Chicago, IL | E | "bag" | NR | $10–$20 | ↑ | NR | NR |
| | Denver, CO | E | NR | 1 gm | $100 | ↔ | 16–18% | ↔ |
| | Washington, DC | L | "dime bag" (white powder) | 50–75 mg | $10 | ↔ | 10–15% | ↔ |
| | | E | "bag" | 1 mg | $1.36 | ↑ | 23% | ↑ |

*Sources: Law enforcement (L) and epidemiologic and ethnographic (E) respondents*
**Respondents in Billings, Portland, and Sioux Falls did not provide this information.*
***Arrows indicate up, down, or stable between fall 2000 and spring 2001.*

In some cities, different dealers use different brand names or logos as a marketing strategy and for identification purposes. In other cities, brand names and logos are nonexistent. Brand names and logos are frequently changed, sometimes on a daily basis. In Baltimore, for example, the ethnographic source states: "Labels change daily. Dealers give out 'testers,' put a label on it, word gets out on what's 'good' that day and in which neighborhoods it's available, then users go to those neighborhoods to make their buys." Philadelphia is another example of a city where heroin brand names proliferate: the number of brand names identified by the epidemiologic source increased from 59 during the last reporting period to 86 during the current period—probably reflecting the dealers' strategy to increase their market. Conversely, New York's ethnographic source reports that "More dealers throughout the city are relying on generic heroin 'non-signature' brands in an effort not to be identified by law enforcement. Some dealers have gone away from name or signature bags and are using bag color to identify the source. Those still using brand names are constantly changing the name to avoid detection from police."

How is heroin packaged? Heroin is most commonly packaged in plastic, cellophane, glassine, or coin bags, usually the "zipper" type, as reported by law enforcement, epidemiologic, and ethnographic sources in every city except Detroit, El Paso, Billings, Denver, and Los Angeles. Other common packaging includes plastic or cellophane wrap (as reported in Baltimore, Chicago, St. Louis, Denver, and Honolulu), wax paper (in Boston, Portland, Baltimore, and Memphis), and balloons (in El Paso, Memphis, Denver, and Los Angeles).

**Exhibit 5.**
**How is heroin referred to, and what types of heroin predominate, in different regions of the country?**




H, boy, horse, dogfood, s--t, negro, chiva, smack, china white, monkey, big, heroin, train, foil, girl, doogie, stuff, mud, slag, dragon, mac, heron, 1-boldstep, magic, revenge, white dragon, jerry springer, orange bag, green bag, red bag, black bag, 747, carga, black coffee, white horse, lady, manteca, diesel, pink, doosey, black tar, bone, shake, grown man, tammy

*Sources: Law enforcement, epidemiologic, ethnographic, and treatment respondents*

Some more unusual packaging is reported: lottery tickets in Detroit; "bricks" of compressed heroin in New York; loose single pills or capsules that melt when heated in Baltimore; double plastic bags with uncooked rice in between (to keep moisture out) in New Orleans; paper wrapping inside of plastic, or in folded magazine pages, in Billings; and latex pellets in Denver. Two recent changes are reported: in Chicago, bags are becoming more common, while foil is becoming rarer; and balloons are no longer used in Baltimore.

## HEROIN: THE SELLERS

**How are street-level heroin sellers organized?** Street-level heroin sellers tend to be independent of organized structures such as gangs, according to 13 of the 20 law enforcement sources who discussed this question. In Portland, ME, for example, most sellers are heroin addicts who go to neighboring Massachusetts to get the drug, import it, and sell it back home; only occasionally does an organized group from Massachusetts come in to sell the drug in Portland, but then they leave. Three additional sources—in Miami, New Orleans, and St. Louis—report both independent and organized sellers in their cities. In Miami, independent sellers are found on the

**What heroin brand names (and logos) are seen in different cities?**

Brand names (dealer designations) and logos are not used in all cities. In cities where they are, including those below, brand names are sometimes—but not always—interchangeable with street names (slang).

| | |
|---|---|
| **Baltimore, MD** | G-money, murder one, john hinkley, code blue; (colored packaging, spider symbols, eagle symbols) |
| **Chicago, IL** | Doorway, one stop; (faces printed on bags) |
| **Columbia, SC** | New york, new york; skull and crossbones; mercedes; plymouth; playboy |
| **Detroit, MI** | Danger; (skull and crossbones) |
| **Miami, FL** | (cartoon characters) |
| **New York, NY** | Tres pesos, shark, first class, america on-line, death certificate, murder, 777, dead president, millenium 2000 |
| **Philadelphia, PA** | 747, 911, bone collector, creeper, devil's advocate, eagle, fatal, m & m, maggie 2, movada, old navy, one life,opium, rabbit, really hot, river, rose, samurai, scorpio, scorpion, super AT&T, super hot, super nautica, thumbs up, timberland, WCW, 7up, bad habit, bart simpson, big mac, body bag, chevrolet, cobra, cold water, colt 45, dead on arrival (DOA), dead.com, demolition, diesel, DMX, do-wop, dracula, fingers, fuega, godfather, holyfield, homicide, I'll be back, K & A, kill over, knock out, land rover, laser, legend, life after death, lucifer, mike tyson, motorola, nautica, no joke, octopus, one and done, pacman, painkiller, poison, star, suicide, super buick, super slow, titanick TNT, tommy hilfiger, too hot to handle, soo strong, toyota, UPS, USA, V-8, viper, white control, white house |
| **Portland, ME** | Red devil, batman, black eagle, TNT |
| **Washington, DC** | Jerry springer, 747, $; (different colored bags) |

streets, while organized sellers conduct their transactions in clubs. Organized sellers predominate in only four *Pulse Check* cities: Chicago, Columbia (SC), Denver, and Seattle. The Seattle organized structure consists of two kinds of sellers: a go-between who is an addict, and "the guy in the car with the bags, who is not an addict," comments that city's law enforcement source. Recently, Asian groups have starting getting involved in heroin sales in New Orleans, and individuals from Russia and Eastern Europe have been getting involved in New York.

Epidemiologic and ethnographic sources paint a slightly different picture: they report organized sales structures in 10 cities. In five of those cities, law enforcement sources, by contrast, report independent operations: Baltimore, Detroit, El Paso, Memphis, and Washington, DC. These seeming discrepancies might be explained by differing definitions of what constitutes an organized group. In Baltimore, for example, the law enforcement source points out that while young adolescent sellers are not in gangs, they do work in small cliques (which might be construed as organized structures). According to that city's ethnographic source, heroin's organized sales structure has three or four tiers between the leader and the individual who delivers the drug to the customer. Similarly, the New Orleans epidemiologic source defines that city's organized structure as a series of loose connections, not gang-related, in which a seller has a dealer who gets calls to arrange pick-ups at specified locations.

**Then and Now:**

**How have street-level heroin sales changed across the country (fall 2000 vs spring 2001)?**

*Only a few changes (none in the Midwest) are reported in the heroin sales scene and in the kind of people who sell the drug at the street level.*

**In the Northeast...**

- **Boston, MA**: The law enforcement source describes heroin sales as being more underground than in the past and than other drug sales.
- **New York, NY**: Individuals from Russia and Eastern Europe are increasingly involved in heroin sales, according to the law enforcement source.
- **Philadelphia, PA**: The epidemiologic source reports that in the past each dealer sold one drug; now, in addition to all the "meat and potatoes" products (that is, heroin, crack cocaine, and marijuana), dealers also sell diverted pharmaceuticals, such as alprazolam (Xanax®) and oxycodone (Percodan®, Percocet®, and OxyContin®).

**In the South...**

- **Baltimore, MD**: According to the law enforcement source, heroin sales activity appears to have increased.
- **Columbia, SC**: The law enforcement source reports an increase in drug dealers robbing other drug dealers, with some robberies resulting in shootings.
- **New Orleans, LA**: Recently, Asian groups have starting getting involved in heroin sales, according to the law enforcement source.

**In the West...**

- **Billings, MT**: The law enforcement source reports that heroin trafficking and sales appear to be down.

Some cities have two kinds of sales structures...

**Honolulu, HI**: The epidemiologic source describes most sellers of heroin, marijuana, methamphetamine, and cocaine as independent, with each seller having two or three "runners" to deliver drugs to customers and return the payments to the seller. Some sellers, however, have Mexican affiliations: youths with minimal English-speaking skills are recruited in Mexico, flown into Hawaii, given addresses via phone identifying where they should report to begin "running" drugs, and then returned to Mexico after 4–6 months.

**Miami, FL:** The law enforcement source notes that independent sellers are found on the streets, while organized sellers conduct their transactions in clubs.

How old are street-level heroin sellers? Young adults (age 18–30) are the group most likely to sell heroin in the street, according to 11 of the 19 law enforcement sources who discussed this question and spanning all regions of the country. Moreover, they are just as likely as older adults (>30 years) to sell street-level heroin in an additional three *Pulse Check* cities (El Paso, Portland, and St. Louis). Older adults are the likeliest to sell heroin in five of the cities: Billings, Honolulu, Memphis, Philadelphia, and Washington, DC.

Only 13 of the epidemiologic and ethnographic sources provided information on this question. Again, the majority (10) name young adults as the primary street-level sellers. Birmingham and Detroit are two of the three exceptions, with older adults more likely to sell heroin; the third exception is Chicago, where, most disturbingly, the epidemiologic source names adolescents (13–17 years) as the most likely to sell heroin on the street. Adolescents, while not the primary seller group in most cities, do sometimes sell heroin. In New York, for example, the epidemiologic source reports that "Street dealers are using teenagers to sell their drugs. These teenagers can be seen on small bikes loitering in front of local grocery stores or on the corners."

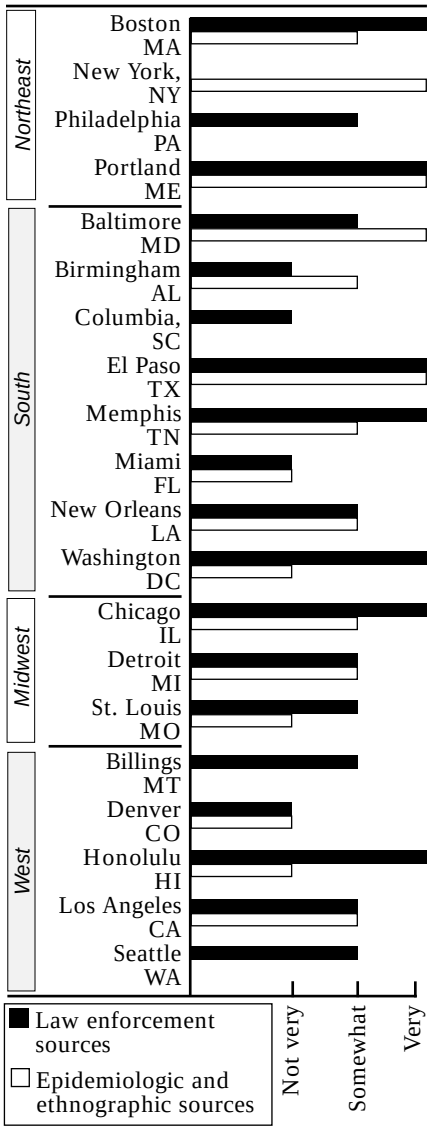
### Does sales location have anything to do with the age of sellers?

The New York ethnographic source notes that "Sellers on the street range in age from the late teens to the late thirties; dealers that sell from indoor locations range in age from the late teens to late fifties."

**What type of crimes are heroin sellers involved in?** All but 1 of the 19 law enforcement sources who discussed this question consider heroin sellers as somewhat or very likely to be involved in criminal activity. The Birmingham source, however, believes that sellers are not very involved in other crimes. Specifically, the law enforcement sources mention nonviolent crime more often than violent crime in association with heroin sales (in 12 versus 8 cities, respectively). Gang-related crime is mentioned in seven cities (none in the Northeast; Baltimore, El Paso, and New Orleans in the South; Chicago and St. Louis in the Midwest; and Honolulu and Seattle in the West). Prostitution is mentioned in six cities (Boston and Philadelphia in the Northeast; El Paso and New Orleans in the South; none in the Midwest; and Denver and Honolulu in the West). Other crimes mentioned by law enforcement sources include pharmaceutical diversion (in Portland, ME), domestic violence (in Boston), and money laundering (in Miami). The Columbia, SC, law enforcement source reports an increase in drug dealers robbing other drug dealers, with some robberies resulting in shootings.

**Do heroin sellers use their own drug?** *(Exhibit 6)* Of the 19 law enforcement sources who discussed this question, 7 consider heroin sellers very likely to use their own drug, 8 give a "somewhat likely" response," and 5 consider them not very likely to do so. The 15 epidemiologic and ethnographic sources who discussed the same question are more evenly divided, with 5 giving each of the above-named responses. One of the "somewhat likely" responses is given by the Boston ethnographic source, who comments that "Nearly all users eventually sell to help sustain their habit, usually just selling because it is a way to procure heroin." That source also notes, however, that young Dominican gang members, who constitute a small proportion of heroin sellers, are unlikely to use their own heroin. On the rare occasions they do, it is with crack. Similarly, the Baltimore the ethnographic source, who describes a sales structure with three or four tiers between the leader and the deliverer, notes that those at the bottom tier are very likely to use their own drug, while the actual seller at the top is not likely to do so.

**Exhibit 6.**
**How likely are heroin sellers to use their own drug?***




*Sources: Law enforcement, epidemiologic, and ethnologic respondents*
**The law enforcement source from New York and the epidemiologic sources from Billings, Columbia, Los Angeles, New York, Philadelphia, Seattle, and Sioux Falls did not provide this information*

**Where is street-level heroin sold?** *(Exhibit 7)* As in the last *Pulse Check* report, law enforcement sources generally agree that most heroin sales take place in central city areas. However, in New York and Portland, it is also sold in rural and

Settings for sales and use vary...

**New York, NY:** The ethnographic source suggests that "Young Whites prefer Staten Island because of its close proximity to New Jersey and indoor selling locations. The buyers prefer paying a higher price (for security and the feeling that you get 'better dope' indoors than on the street) at indoor locations in New Jersey than to travel to outdoor locations in Brooklyn and Manhattan."

**Miami, FL:** According to the law enforcement source, "distributors find someone in the central city, beep that person, then they meet. Often, they meet in the suburbs for delivery."

**Baltimore, MD:** The ethnographic source notes that street-selling locations include open air markets. Indoor sales include some unusual settings, such as locally run fried chicken restaurants with plexiglass drive-up windows where drug transactions take place. Additionally, the law enforcement source describes slots, cut into vacant buildings, where "money goes in and drugs go out."

suburban areas; in Memphis, it is also sold in rural areas; and in Miami, it is also sold in the suburbs. Epidemiologic and ethnographic sources also generally concur that central city areas are the most common sites for heroin sales. Two exceptions, however, are Miami and Sioux Falls, where suburban areas are reported as more common. Additionally, a rural border crossing area in El Paso is seeing much heroin sales activity.

Indoor and outdoor sales are equally common, according to the majority (13 of 20) of responding law enforcement sources. Indoor sales, however, are reportedly more prominent in Boston, Detroit, Memphis, and Portland; while outdoor sales are more evident in Baltimore, Honolulu, and Philadelphia. Most epidemiologic and ethnographic sources (10 of 15) concur that heroin sales are equally likely to take place indoors and outdoors, but indoor sales are reportedly more common in four sites (Miami, New York, Portland, and Sioux Falls), while outdoor sales are more

**Exhibit 7. Where is street-level heroin sold and used?***

| | Site | Street | | Private Residence | | Public Housing | | Private Parties | | Crack Houses | | Inside Cars | | Playgrounds/ Parks | | Raves | | Night-Clubs | | College Campus | | Schools | | Shopping Malls | | Total # of Settings | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell |
| *Northeast* | Boston, MA | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | ✓ | | ✓ | | | | | | | | | | | | 2 | 6 |
| | New York, NY | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | 9 | 12 |
| | Philadelphia, PA | | ✓ | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | | | | | | | | | ✓ | | | 3 | 4 |
| | Portland, ME | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | | | | | 8 | 3 |
| *South* | Baltimore, MD | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | 10 | 9 |
| | Birmingham, AL | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | | | ✓ | | | | | | | 3 | 7 |
| | Columbia, SC | | ✓ | | | | ✓ | | | | | | | | | | | | | | | | | | | NA | 2 |
| | El Paso, TX | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | 12 | 11 |
| | Memphis, TN | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | | | 9 | 9 |
| | Miami, FL | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | 7 | 12 |
| | New Orleans, LA | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | | | | | ✓ | | ✓ | 3 | 10 |
| | Washington, DC | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | | ✓ | | ✓ | | | | | | | | | | | 3 | 5 |
| *Midwest* | Chicago, IL | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ | | | | | | ✓ | | ✓ | | | 6 | 7 |
| | Detroit, MI | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | | | | | | | | | | | | | | 4 | 4 |
| | St. Louis, MO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | | ✓ | | | | | | | | ✓ | | ✓ | 4 | 8 |
| | Sioux Falls, SD | | | | ✓ | | ✓ | ✓ | ✓ | | | | | | | | | | | | | | | | | 1 | 3 |
| *West* | Billings, MT | | ✓ | ✓ | | | | ✓ | ✓ | | | ✓ | ✓ | | | | | | | | | | | | | 3 | 3 |
| | Denver, CO | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | | | ✓ | ✓ | | ✓ | | | 5 | 9 |
| | Honolulu, HI | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | | | | ✓ | | | | | 2 | 9 |
| | Los Angeles, CA | | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ | | | | | ✓ | | | | | | | | | 3 | 3 |
| | Seattle, WA | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ | ✓ | | | | ✓ | ✓ | ✓ | ✓ | | | | | 8 | 6 |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents for seller settings*
*Epidemiologic and ethnographic respondents for user settings*
**The law enforcement sources in Sioux Falls, and the epidemiologic/ethnographic sources in Billings, Columbia, Los Angeles, and Seattle, did not provide seller setting information. The epidemiologic source in Columbia did not provide user setting information.*

prominent in Washington, DC. The New York ethnographic source elaborates that heroin continues to be sold mostly indoors because of law enforcement initiatives aimed at street sales. Similarly, the Boston law enforcement source describes heroin sales as being more underground than in the past and than other drug sales.

As the chart shows, law enforcement, epidemiologic, and ethnographic sources report a wide range of specific settings for heroin sales:

- Private residences and public housing developments: Mentioned in nearly every *Pulse Check* city
- Private parties, crack houses (or "crash houses," as the Memphis law enforcement source terms them), cars, and parks or playgrounds: Common venues
- Raves and nightclubs: Particularly common in the South, but not mentioned in the Midwest
- Schools and college campuses: Mentioned, respectively, in eight and seven cities–with both venues reported in four cities representing four different regions: Billings, Chicago, Memphis, and New York
- Shopping malls: Mentioned in five cities

Other heroin sales venues, not depicted in the chart, are also reported by law enforcement, epidemiologic and ethnographic sources:

- In or near supermarkets: In Billings, Columbia (SC), El Paso, Honolulu, New York, and New Orleans
- Over the Internet: In El Paso, Honolulu, and New York
- Hotels and motels: In Memphis

### How is street-level heroin sold?

As in the last *Pulse Check* report, hand-to-hand sales remain the most common way to sell user-level heroin, as reported by each of the 20 law enforcement sources who discussed this question. Sales involving beepers or cell phones are the second most commonly reported (in 14 cities), followed by the home delivery method (which also commonly involves beepers or cell phones) (in 11 cities) and acquaintance networks (in 10 cities). In the Midwest, the Detroit law enforcement source describes car "meets" with dealers by appointment, while the St. Louis source reports that sellers are becoming more guarded about what they say on cell phones. The Los Angeles law enforcement source, however, reports that dealers, after being paged to call the buyer, use sophisticated digital cell phone systems that create difficulties for narcotics officers to monitor or track person-to-person transactions.

Epidemiologic and ethnographic sources, similarly, report that hand-to-hand and beeper/cell phone sales are the most common (in 12 cities each), followed by acquaintance networks (in 9 cities) and home delivery (in 6 cities). New York features office delivery service. The Honolulu epidemiologic source describes a typical high-risk scenario: a buyer tells a runner what drug he wants, the runner then finds out the cost, returns to collect the money, then leaves and comes back to "make the drop."

### What other drugs do heroin dealers sell?

*(Exhibit 8)* Heroin dealers continue to sell additional drugs in nearly every *Pulse Check* city, except

**Exhibit 8.**
**What other drugs do heroin dealers sell?***

| | City | Crack | Powder Cocaine | Marijuana | Other | No other drug sold |
|---|---|---|---|---|---|---|
| Northest | Boston, MA | | | | | ✓ |
| | New York, NY | ✓ | ✓ | ✓ | Ecstasy | |
| | Philadelphia, PA | ✓ | | ✓ | Alprazolam (Xanax®)<br>Oxycodone (all forms) | |
| | Portland, ME | | | | OxyContin®<br>Other pharmaceutical opiates | |
| South | Baltimore, MD | | ✓ | | | |
| | Birmingham, AL | ✓ | ✓ | ✓ | | |
| | Columbia, SC | | | | | ✓ |
| | Memphis, TN | | ✓ | ✓ | | |
| | Miami, FL | | ✓ | | Ecstasy | |
| | New Orleans, LA | ✓ | ✓ | ✓ | | |
| | Washington, DC | ✓ | ✓ | | | |
| Midwest | Chicago, IL | ✓ | ✓ | | | |
| | Detroit, MI | ✓ | ✓ | ✓ | | |
| | St. Louis, MO | ✓ | | ✓ | | |
| West | Billings, MT | | | | | ✓ |
| | Denver, CO | ✓ | ✓ | ✓ | Methamphetamine | |
| | Honolulu, HI | | | | | |
| | Seattle, WA | ✓ | ✓ | ✓ | | |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
**Respondents in El Paso, Los Angeles, and Sioux Falls did not provide this information.*

for Billings, Boston, Columbia (SC), and Honolulu, where neither law enforcement, epidemiologic, nor epidemiologic sources indicated such sales. Crack and powder cocaine are mentioned most frequently, followed by marijuana. Also mentioned are ecstasy (methylenedioxymethamphetamine, or MDMA) (in Miami and New York), pharmaceutical opiates such as OxyContin® (in Portland), and methamphetamine (in Denver). The Philadelphia epidemiologic source reports that in the past each dealer sold one drug; now, in addition to all the "meat and potatoes" products (that is, heroin, crack cocaine, and marijuana), dealers sell diverted pharmaceuticals, e.g., alprazolam and oxycodone (Percodan®, Percocet®, and OxyContin®). In Baltimore, some heroin sellers also sell powder cocaine, sometimes as a "one-and-one" (both drugs sold together as a unit); other dealers, however, sell the drugs separately. With Memphis heroin dealers also selling cocaine in various mixes, that city's epidemiologic source notes that buyers often don't know what they're getting. In St. Louis, dealers affiliated with gangs are particularly likely to run a "one-stop shop," selling heroin, crack, and marijuana.

**Then and Now:**

**How have heroin user demographics changed across the country (fall 2000 vs spring 2001)?**

***According to epidemiologic and ethnographic sources...***

**Age:** *Numerous shifts are reported:*

- Increases in the young adult (18–30 years) group are reported in the majority of *Pulse Check* cities: Boston in the Northeast; Baltimore, Columbia, Memphis, Miami, and Washington, DC, in the South; Detroit, St. Louis, and Sioux Falls in the Midwest; and Denver, Honolulu, and Seattle in the West.
- A new user group is emerging in El Paso: adolescents born into multigenerational families of heroin addicts and sellers (but young adults age 18–30 still predominate).
- More younger people (16–22 years) in Portland, ME, are initiating heroin use.

**Race/ethnicity:** *Distributions remain generally stable except for five reported shifts:*

- **Denver, CO:** Whites, who are the predominant heroin user group, continue to increase as a percentage of heroin users; however, they are still underrepresented relative to the city's general population.
- **Miami, FL:** Hispanics are an emerging group (but are still underrepresented relative to the general population).
- **Philadelphia, PA:** The proportion of Whites among heroin users has declined slightly, while Black and Hispanic representation has increased slightly.
- **Seattle, WA:** Slight increases are reported in heroin use by Hispanics.
- **Washington, DC:** Blacks remain the racial/ethnic group most likely to use heroin, but Whites have been increasingly using the drug.

**Gender:** *Distributions remain stable, with three exceptions: the number of female heroin users has increased slightly in New Orleans, Philadelphia, and Portland (ME).*

**Residence:** *Heroin use is spreading to the suburban areas surrounding four* Pulse Check *cities in the South (Baltimore, Memphis, Miami, and Washington, DC) and Seattle in the West. Use is also spreading to the rural areas surrounding Portland, ME (as suggested by rising hepatitis C figures), and El Paso (partly because many people are moving there).*

## HEROIN: THE USERS

### How old are heroin users?

*(Exhibit 9)* The vast majority of epidemiologic and ethnographic sources (17 of 21) in the *Pulse Check* sites agree that the people most likely to use heroin are generally older than 30. However, younger adults (18–30 years) sometimes comprise substantial proportions of users in those sites. Furthermore, in the South, younger adults are more likely than older adults to use heroin in four sites: Baltimore, El Paso, Memphis, and New Orleans. In two sites—Philadelphia and St. Louis—both the younger and older adult groups are cited as equally likely to use heroin. Moreover, the younger adult groups are increasing in many cities, such as Portland (ME) and Sioux Falls, where the older adults still predominate. Even more disturbingly, in some cities, including Baltimore, El Paso, and Portland, adolescents are increasingly initiating heroin use. By contrast, in Boston, the ethnographic source remarks that "It's rare to see young minority heroin users. They often saw its effects on their parents and tend not to use it."

The two Philadelphia treatment sources agree with that city's

epidemiologic source that both the younger and older adult age groups are equally likely to use heroin. A similar consensus among all source categories occurs in Birmingham, Boston, Detroit, and Honolulu, where heroin users are perceived to be primarily older adults, and in New Orleans and St. Louis, where they are perceived to be primarily young adults. Overall, heroin users in methadone programs seem to be somewhat older than those in non-methadone treatment: 10 out of 17 (59 percent) methadone treatment sources who discussed this question consider heroin users more likely to be older adults, versus 8 out of 18 (44 percent) non-methadone sources. Another disturbing report comes from Chicago, where the methadone program's heroin users are primarily both adolescents and young adults.

**Then and Now:**

**How have heroin user demographics changed across the country (fall 2000 vs spring 2001)?**

***According to treatment sources...***

*The number of novice heroin users (any drug treatment client who has recently begun using heroin) in methadone and non-methadone treatment has increased in five methadone programs (in Billings, Denver, El Paso, St. Louis, and Portland) and five non-methadone programs (in Boston, Chicago, Columbia, El Paso, and Miami) across nine* Pulse Check *cities. Additionally, that number has increased in the teen facility of the Honolulu non-methadone program while the number adult novice users has remained stable. Stable numbers are reported in all other programs where this information was available: in 10 non-methadone programs (in Baltimore, Billings, Birmingham, Boston, Chicago, Columbia, Honolulu, Miami, New Orleans, and Philadelphia), and in 7 methadone programs (in Birmingham, Boston, Chicago, Honolulu, New Orleans, St. Louis, and Seattle). No declines are reported.*

*In addition to changes in the number of novice users, only a handful of* Pulse Check *treatment sources report any demographic changes between fall 2000 and spring 2001:*

| Non-methadone programs | Methadone programs |
|---|---|
| **Gender shifts:** In Baltimore, more female heroin users have been entering treatment; nevertheless, the program's heroin-using population remains predominantly male. In Honolulu, males and females used to be evenly represented among heroin users; now the program's heroin users are predominantly males.<br><br>**Residence shifts:** While clients in the El Paso non-methadone program are predominantly suburban, central city representation is increasing. | **Younger clients:** Heroin users coming into one of the two Boston methadone programs represented in *Pulse Check* appear to be younger than in the past.<br><br>**Older clients:** Heroin users in Columbia (SC), El Paso, and Portland (ME) appear to be older than in the past. |

Recent age shifts among heroin users in treatment: Some possible explanations...

Only four treatment sources report any recent changes relating to age. In one of the two Boston methadone programs, heroin users entering treatment appear to be a little younger than previously. The *Pulse Check* source speculates that this shift might be occurring because younger people who have been abusing diverted oxycodone (in the OxyContin® form) might be unable to sustain the costs of that drug. Conversely, heroin clients coming into the Columbia (SC), El Paso, and Portland methadone programs appear older than in the past. The Columbia source explains that users must be addicted for at least a year to be admitted. Similarly, the El Paso source speculates that people are taking longer to come in for treatment.

Are there gender differences in who uses heroin? *(Exhibit 9)* All but 2 of the 21 epidemiologic and ethnographic sources agree that males are more likely than females to use heroin, at least among the largest user groups. The exceptions are in Birmingham and Washington, DC, where males and females are equally likely to use the drug. Since the last *Pulse Check* reporting period, the number of female heroin users has increased slightly in New Orleans, Philadelphia, and Portland (ME).

Similarly, the vast majority of reporting non-methadone treatment sources cite males as the largest heroin-using group. In methadone treatment programs, however, males and females are equally likely to use heroin, as reported by 10 of 17 methadone treatment sources who discussed this question. The only changes reported are in two non-methadone programs: increases in female heroin users entering the Baltimore program (which remains predominantly male) and in male users entering the Honolulu program (which used to be evenly split but is now predominantly male).

**Exhibit 9.**
**What demographic groups predominate among heroin users, according to different *Pulse Check* sources?***

| | City | Age | | | Gender | | | Race/Ethnicity | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | E | N | M | E | N | M | E | N | M |
| Northeast | Boston, MA | >30 | 18–30; >30 | 18–30; >30 | Males | Males | Both | Whites | Whites | Whites |
| | New York, NY | >30 | 18-30 | >30 | Males | Females | Males | Whites | Whites | Whites |
| | Philadelphia, PA | 18–30; | 18–30; | 18–30; >30 | Males >30 | Males >30 | Males | Whites | Blacks, Hispanics | Whites |
| | Portland, ME | >30 | >30 | >30 | Males | Males | Both | Whites | Whites | Whites |
| South | Baltimore, MD | 18–30 | >30 | >30 | Males | Males | NR | **Blacks** | Blacks | NR |
| | Birmingham, AL | >30 | >30 | >30 | Both | Males | NR | **Whites**/ Blacks | **Blacks** | NR |
| | Columbia, SC | >30 | NR | 18–30 | Males | Males | Both | Whites/ Blacks | NR | NR |
| | El Paso, TX | 18–30 | NR | >30 | Males | Males | Males | Hispanics | **Hispanics** | Hispa- |
| | Memphis, TN | 18–30 | NR | NR | Males | Males | NR | **Whites** | NR | NR |
| | Miami, FL | >30 | >30 | 18-30 | Males | Males | Males | Whites | Hispanics | NR |
| | New Orleans, LA | 18–30 | >30 | >30 | Males | Males | Both | **Blacks** | Blacks | **Whites** |
| | Washington, DC | >30 | 18–30 | >30 | Both | Both | Males | **Blacks** | Blacks | Blacks |
| Midwest | Chicago, IL | >30 | >30 | 18-30 | Males | Males | Both | **Blacks** | **Blacks** | **Blacks** |
| | Detroit, MI | >30 | >30 | >30 | Males | Males | Both | Whites | **Blacks** | Blacks |
| | St. Louis, MO | 18–30; >30 | >30 | >30 | Males | Males | Both | Blacks | **Blacks** | NR |
| | Sioux Falls, SD | >30 | 18–30 | NA | Males | Males | NA | Whites | NR | NA |
| West | Billings, MT | >30 | 18–30 | NA | Males | Both | NA | Whites | Whites | NA |
| | Denver, CO | >30 | >30 | 18–30 | Males | Males | Both | Whites | Whites | Whites |
| | Honolulu, HI | >30 | >30 | >30 | Males | Both | Males | Whites | **Whites** | **Whites**/ Asians |
| | Los Angeles, CA | >30 | NR | >30 | Males | Males | Both | Hispanics | NR | Hispanics |
| | Seattle, WA | >30 | NR | >30 | Males | Males | Both | Whites | NR | Whites |

*Sources: Epidemiologic/ethnographic (E), non-methadone treatment (N), and methadone treatment (M) respondents*
**Shaded boxes indicate that a given heroin-using racial/ethnic group is overrepresented relative to that city's general population. Not all sources, however, had this information available.*

Is any racial/ethnic or socioeconomic group more likely to use heroin? *(Exhibit 9)* According to epidemiologic and ethnographic sources, heroin users are most likely to be Whites in 12 *Pulse Check* cities and Blacks in five cities. Whites and Blacks are equally represented among heroin users in Birmingham and Columbia (SC), and Hispanics are the predominant user groups in El Paso and Los Angeles. Epidemiologic and ethnographic sources also note that some racial/ethnic groups who are not the most likely to use heroin in their cities are, nevertheless, overrepresented. For example, in Denver and Philadelphia, Whites predominate in heroin use, but Hispanics are overrepresented relative to the general population. Similarly, in Boston, where Whites are in the majority among heroin users, Blacks are nevertheless overrepresented.

### Demographic differences between clients in methadone and non-methadone programs...

According to *Pulse Check* treatment sources, heroin-using clients in the two types of programs differ somewhat in age and gender distributions:

- **Age:** Overall, heroin users in methadone programs seem to be somewhat older than those in non-methadone treatment.
- **Gender:** Heroin users in the non-methadone programs are predominantly males. Even gender distributions are much more common in methadone programs.
- **Race/Ethnicity:** Methadone treatment sources are more likely to report Whites as the predominant heroin user group in their programs, while non-methadone treatment sources are more likely to report Blacks.
- **Socioeconomic status (SES):** Heroin users in methadone programs are more likely than those in non-methadone programs to be from middle SES backgrounds. Conversely, those from non-methadone programs are more likely to be from low SES backgrounds.
- **Employment and education:** Employment rates and education levels are higher among heroin users in methadone programs than among those in non-methadone programs.
- **Residence:** Suburban representation is somewhat higher among heroin users in methadone treatment than among those in non-methadone treatment.

Only a few minor changes are reported by epidemiologic and ethnographic sources. In Washington, DC, for example, Whites, have been increasingly using heroin, but they still reflect their distribution in the general population and are still not the predominant user group. In Denver, Whites, who are the predominant heroin user group, have been increasing; however, they are still underrepresented relative to the city's general population. And in Philadelphia, the proportion of Whites among heroin users has declined slightly, while Black and Hispanic representation has increased slightly. Heroin use by Hispanics has also increased slightly in Seattle.

*Pulse Check* treatment sources similarly report diverse racial/ethnic distributions at their programs. Whites are the predominant heroin user group in nine methadone programs but only six non-methadone programs. Conversely, Blacks are the primary user group among heroin clients in eight non-methadone programs but only four methadone programs. Hispanics are more likely than other groups to use heroin at the El Paso and Miami non-methadone programs and at the El Paso and Los Angeles methadone programs, and they equal Blacks as the primary heroin-using group in the Philadelphia non-methadone program. In Honolulu, heroin users at the methadone program are about half Asians and half Whites; the non-methadone program's teen center has primarily Asian heroin clients, while that program's adult center heroin clients are primarily Whites. No treatment sources report any major changes in racial/ethnic distributions since the last *Pulse Check* reporting period.

What is the most common socioeconomic background of heroin users? In all but four of the *Pulse Check* cities, the largest heroin-using group reported by epidemiologic and ethnographic sources is in the low SES category. Heroin users are more likely to be middle SES in Memphis (where they have increased), Miami, and Sioux Falls, while the Detroit source reports that all SES groups are equally likely to use heroin.

Similarly, the vast majority of non-methadone treatment sources report that their programs' heroin-using clients are from low SES backgrounds. Only four programs are exceptions: in Billings, where high SES clients predominate; in Honolulu, where the middle SES is named; and in Boston and Washington, DC, where heroin clients are equally likely to be from either low or middle SES backgrounds.

### Conditions that contribute to low socioeconomic status among non-methadone clients...

The Washington, DC, non-methadone source explains that SES is low at the program for three reasons: lack of employment; lack of education; and lack of family support resulting from the addicts' drug use.

Methadone treatment providers are the only *Pulse Check* sources who name middle SES more frequently than low SES as the predominant status of their heroin clients: of the 15 respondents who discussed this question, 8 name the former, 5 name the latter, and 2 name both low and middle SES clients as equally represented. This finding is not surprising because methadone clients tend to be on long-term maintenance, so they are less likely to be currently active drug users and are more likely to be employed and to be able to afford treatment fees.

Employment figures from both types of treatment programs bear out this explanation to some extent. Less than half of clients are employed, either part-time or full-time, in 12 of 14 non-methadone programs but in 8 of 14 methadone programs where this information was available.

### Middle socioeconomic heroin users: A hidden population?

**St. Louis, MO:** Heroin users often come from low SES backgrounds, as in St. Louis. But that city's epidemiologist points out that middle SES heroin users might be a hidden population because they tend to use private physicians for treatment.

What is the education level of heroin users? According to responding treatment sources, heroin users in methadone treatment seem to have a higher education level than those in non-methadone programs. Among the 17 methadone treatment sources who provided this information, only 4 report that the majority of their programs' clients have not completed high school (in Chicago, Detroit, Los Angeles, and Philadelphia); the comparable dropout figures for the non-methadone are 7 out of 13 responding programs. El Paso provides an example of the disparity in education levels between the two types of heroin users: the majority in the non-methadone program have only completed junior high, while the majority of those in the methadone

program are split evenly between people who have completed high school and those who have completed 2 years of college. In two other programs, *Pulse Check* sources report that heroin users have completed 2 years of education beyond high school: the methadone program in New York, and the non-methadone program in Honolulu.

**Where do heroin users tend to reside?** Central city areas are generally cited by epidemiologic and ethnographic sources as the most likely place of residence for heroin users. The suburbs, however, are the most likely residence area for heroin users in Sioux Falls and Los Angeles. In Detroit, heroin users are equally likely to reside in both central city and suburban areas Additionally, many smaller heroin-using populations reside in suburban areas, as mentioned in at least two northeastern areas (Boston and New York), four southern areas (Baltimore, Memphis, Miami, and Washington, DC), three western areas (Denver, Honolulu, and Seattle), and one midwestern area (Chicago). An increasing spread of heroin use to suburban areas is reported by several epidemiologic and ethnographic sources, including those in Baltimore, Memphis, Seattle, and Washington, DC.

**New York, NY: The drug and the user on the move...**

According to the New York ethnographic source, "Researchers report that young Whites, both males and females, continue to come to Brooklyn to purchase heroin and use the needle exchange programs. The heroin and needles are transported back to Long Island, where they are sold."

Some heroin users reside in rural areas, as reported in Portland, El Paso, and St. Louis. In Portland, rising hepatitis C figures suggest an increase of heroin use in those rural areas, but heroin users continue to reside predominantly in the central city. In El Paso, heroin users are most likely to reside in several barrios in the central city; however, heroin is increasingly reported in the rural areas, partly because many people are moving into those areas. The St. Louis epidemiologist is watching for growth in the heroin-using population in Springfield, Missouri—once considered a rural area, but now becoming more urbanized. This latter case shows how the lines between city, suburban, and rural areas are often becoming blurred.

*Pulse Check* treatment sources also name the central city more frequently than other areas. Among the 15 non-methadone sources who discussed the subject, only 2 (in Denver and in El Paso) report that their clients are more likely to be suburban, and 1 (in Honolulu) reports that adult clients

**Then and Now:**

**How have heroin use patterns changed across the country (fall 2000 vs spring 2001)?**

***According to epidemiologic and ethnographic sources...***

*Sources in three regions—particularly in the South— report some slight changes in the way heroin users take their drug and in the other drugs they use. No such changes are reported in the Midwest.*

- **Increased snorting:** While injecting still predominates, snorting has increased in Columbia (SC), Denver, El Paso, Miami, New Orleans, and Washington, DC.
- **Increased smoking:** Smoking has increased in Denver and Memphis, but injection remains the primary route of administration in both cities.
- **Increased injecting:** In Honolulu, some young adults are shifting from "chasing the dragon" to needle use.
- **Increased crack combinations:** Speedballs containing heroin plus crack have increased in El Paso (where they used to include only powder cocaine, but now crack cocaine is as likely to be included as powder) and in Los Angeles (where speedballs continue to contain primarily heroin plus powder cocaine).
- **Changes in benzodiazepine use:** Alprazolam use, common among Philadelphia heroin addicts, has been increasing, while diazepam use has been declining.
- **Increased ecstasy use:** Heroin combined with ecstasy has recently been reported in Memphis (as users move away from crack) and Miami.

***According to treatment sources...***

*Use patterns remain relatively stable in the treatment population. Only two changes are reported. In Philadelphia, the* Pulse Check *methadone treatment source reports a shift from injecting to snorting due to increased heroin purity. And in Birmingham, the non-methadone treatment source notes a "trail mix" used by adolescents, consisting of heroin, cocaine, and ecstacy, which showed up about a year ago.*

are most likely to be from rural areas (although clients at that program's teen facility are more likely to be from the central city). The El Paso source adds that even though clients are predominantly suburban, central city representation is increasing. The St. Louis source mentions that while the largest proportion of clients are from central city areas, a large proportion also resides in the suburbs.

Methadone treatment sources report slightly higher suburban representation than their non-methadone counterparts: of the 15 sources who discussed this subject, 4 report the suburbs as the likeliest place of residence (in Boston, Columbia (SC), Denver, and New Orleans), and another 2 (in Los Angeles and Seattle) report suburban and central city areas as equally likely places of residence.

How do heroin users administer heroin? *(Exhibit 10)* As in the last *Pulse Check* report, injecting remains the most common route of heroin administration, according to epidemiologic and ethnographic sources in the majority of cities. Snorting, however, either equals or surpasses injecting in nine sites, including all four midwestern sites. Since the last *Pulse Check* reporting period, smoking has reportedly increased in Memphis, where the heroin is smoked in combination with other drugs, and in Denver (continuing a trend ongoing since the early 1990s). Heroin smoking is also occasionally reported in Miami, usually related to the European tourist scene. Some young adults in Honolulu are reportedly shifting from "chasing the dragon" (placing heroin on aluminum foil, lighting a fire underneath it, and sniffing the resulting smoke through a straw or other means) to needle use.

**Exhibit 10.**
**How do users administer heroin?**

| | Injecting is most common in... | Snorting is most common in... |
|---|---|---|
| *Northest* | Boston, MA[E*,M,N*]<br>New York, NY[M*]<br>Philadelphia, PA[E,N]<br>Portland, ME[E, M] | Boston, MA[E*,M,N*]<br>New York, NY[E,M*]<br>Philadelphia, PA[M]<br>Portland, ME[N] |
| *South* | Baltimore, MD[N]<br>Birmingham, AL[E*,N]<br>Columbia, SC[E,M]<br>El Paso, TX[E,M,N]<br>Memphis, TN[E]<br>Miami, FL[E,M,N]<br>New Orleans, LA[E,N]<br>Washington, DC[E,M] | Baltimore, MD[E]<br>Birmingham, AL[E*]<br>New Orleans, LA[M]<br>Washington, DC[N] |
| *Midwest* | Detroit, MI[E*,M]<br>St. Louis, MO[E,M] | Chicago, IL[E,M,N]<br>Detroit, MI[E*]<br>St. Louis, MO[E*,N]<br>Sioux Falls, SD[E,N] |
| *West* | Billings, MT[N*]<br>Denver, CO[E]<br>Honolulu, HI[E,M,N]<br>Los Angeles, CA[E,M]<br>Seattle, WA[E,M] | Billings, MT[E,N*]<br>Denver, CO[M,N] |

**Respondent considers injecting and snorting as approximately equal.*
*[E]Epidemiologic/ethnographic respondents*
*[N]Non-methadone treatment respondents*
*[M]Methadone treatment respondents*
*NOTE: One of the two treatment sources in the following cities did not provide this information: Billings, Birmingham, Columbia, Los Angeles, Memphis, Sioux Falls, and Seattle.*

The epidemiologic source suggests, however, that they might switch back to chasing the dragon if white heroin continues to become increasingly available.

*Pulse Check* methadone treatment sources concur that injection is the most common route for administering heroin, as reported in 12 out of 17 cities where this information was available. The exceptions are five programs in Chicago, New Orleans, and Philadelphia (where snorting is more common), in New York (where snorting and injecting both predominate), and in Denver (where snorting and smoking both predominate). In the New York program, new patients, compared to the overall heroin-using population, are much more likely to snort than inject—about 60–70 percent are snorters. Similarly, in Boston, novice users are primarily snorters, while the program's overall heroin-using population are primarily injectors. In the Philadelphia program, the *Pulse Check* source reports a shift from injecting to snorting due to increased heroin purity.

### Do route of administration and demographics interrelate?

Several epidemiologic and ethnographic sources note a strong relationship between these two variables, as in the following examples:

- **New York, NY:** "The younger crowd prefer snorting," notes the ethnographic source, "because they feel they can't get addicted and they fear contracting HIV.... Sharing of needles by older drug users continues to increase as people live longer with the virus. The feeling is it's okay to share your works."
- **St. Louis, MO:** Snorting has overtaken injecting for the first time in St. Louis (although the two are nearly equal), "probably," notes the epidemiologic source, "because of the increase in young adults who tend to snort." Injection, however, still predominates in that city's rural areas.
- **Detroit, MI:** Young adult heroin users tend to snort the drug; the older user group, however, is equally likely to snort and inject it.

Snorting is mentioned much more frequently by *Pulse Check* non-methadone sources than by their epidemiologic, ethnographic, and methadone treatment counterparts. Out of 16 sources who provided this information, 6 cited snorting as the most common route used by their programs' heroin users, 7 cited injecting, 1 cited both snorting and injecting, 1 cited smoking, and 1 cited both snorting and smoking.

What other drugs do heroin users take? Cocaine is the drug most often taken along with heroin, either in combination ("speedballing") or sequentially, according to epidemiologic and ethnographic sources in the majority of *Pulse Check* cities. Speedballs can involve either powder cocaine (often cooked) or crack (sometimes dissolved). They are generally injected, but they can also be smoked or snorted. In Baltimore, for example, "bipping" refers to snorting heroin or cocaine, either separately or together. Speedballing in that city usually involves injecting heroin and powder cocaine that are cooked together; less often it involves heroin combined with crack. Similarly, in Seattle, heroin and powder cocaine are injected simultaneously, while heroin and crack are smoked sequentially. In Miami, speedballs are heroin plus crack, which may be smoked or snorted rather than injected. Sequential use of the two drugs is more common than speedball use in some cities, such as Columbia (SC) and St. Louis.

Often, the choice of speedballs is related to demographic variables. In New York, for example, the ethnographic source notes that "in speaking with many heroin addicts...older addicts prefer speedballing because the effect is greater when heroin is mixed with cocaine."

Speedballing is also frequently mentioned by treatment sources. Specifically, heroin plus powder cocaine is used by clients in 15 programs, and heroin plus crack is used by clients in 16 programs.

To enhance the effects of heroin, heroin users also sometimes consume benzodiazepines, such as alprazolam, as noted by epidemiologic and ethnographic sources in Baltimore, Boston, Philadelphia, and Seattle. The Baltimore ethnographic source notes that some heroin injectors purchase alprazolam as a heroin substitute (depending on the price of heroin) to "get out the gate"–that is, to get their first shot ("gate shot") in the morning until they can "do a hustle for the dopeman."

Clonazepam (Klonopin®) is another benzodiazepine taken by Boston and Seattle heroin users. The Boston ethnographic source notes that "benzodiazepine-heroin mixers are generally working to middle class." In El Paso, some users of speedballs (heroin plus powder cocaine) also use flunitrazepam (Rohypnol) to help them sleep and "soften the fall when coming down." Additionally, the Honolulu and Seattle methadone treatment sources mention that heroin users also take benzodiazepines. In Honolulu, such users usually alternate between the two drugs; however, a few inject them simultaneously.

When heroin is scarce or low in purity in some cities, users sometimes supplement or replace it with other opiates. Such is the case in El Paso, where heroin users in the non-methadone treatment program sometimes use diverted propoxyphene (Darvon®) and other opiates. In Birmingham, however, the reverse holds true: according to the epidemiologic source, the prescription drug hydromorphone (Dilaudid®) is illegally sold and and more available than heroin, so heroin may be used as a supplement or replacement.

Marijuana is another drug frequently smoked by heroin users, as mentioned by epidemiologic and ethnographic sources in Columbia (SC), Philadelphia, St. Louis, and Seattle. Methamphetamine is sometimes combined with heroin, as mentioned in Honolulu (where that combination is sometimes called a "speedball") and Billings.

The Memphis epidemiologic source notes an increased tendency to mix heroin with other drugs, with the latest mixture being heroin plus ecstasy. The heroin-ecstasy combination is also mentioned by the Miami epidemiologic source. In Birmingham, the non-methadone treatment source notes a "trail mix" used by adolescents, consisting of heroin, cocaine and ecstacy, which showed up about a year ago.

Where and with whom is heroin used? *(Exhibit 7)* Heroin use tends to be an indoor activity. Only two epidemiologic and ethnographic sources, in El Paso and Honolulu, perceive that outdoor use is more frequent than indoor use. An additional three, in Boston, Memphis, and Washington, DC, perceive indoor and outdoor use to be about equal. Street use does, however, take place to some extent, as reported in 12 sites. Similarly, parks and playgrounds are reported as heroin use areas in 10 sites. The Baltimore ethnographic source points out that heroin use tends to take place indoors due to its illegal nature; but outdoor use tends to increase seasonally, as the weather

improves, especially in parks and playgrounds. The Boston ethnographic source adds that "All users seek the most private available setting. The homeless use a public restroom or back alley because that is the most private place they can find."

*Pulse Check* treatment sources concur that most heroin use takes place indoors, as reported by all but four respondents: in Boston (non-methadone and methadone), Denver (non-methadone), and Honolulu (methadone).

The indoor settings most commonly cited (by 10 or more of the 20 epidemiologic and ethnographic sources who discussed this question) are private residences, public housing developments, private parties, cars, and crack houses. Raves and nightclubs are cited in only six sites each, schools are cited in El Paso and Memphis, and shopping malls are also cited in El Paso and New York. In El Paso, in addition to every aforementioned use setting, the epidemiologic source lists some unusual settings, such as jails, court bathrooms, public bathrooms, alleys, and side roads. Indoor settings in Baltimore include abandoned row houses, otherwise known as "abandominiums," as well as bathrooms in fast-food restaurants. Abandoned buildings, rarely used buildings, and public restrooms are also mentioned by the ethnographic source in Boston.

Treatment sources paint a similar picture of the various indoor heroin use settings, with the top-six responses (in order of response frequency) being private residences, crack houses, cars, public housing, parties, and nightclubs.

One unusual setting, described by the Honolulu methadone treatment source, is parties for heroin users that take place in the dealer's home.

"Abandonimiums," public bathrooms, and other unusual heroin use settings...

**Baltimore, MD:** "Abandominiums," according to the epidemiologic source, are abandoned row houses where users shoot heroin. Users also inject heroin in the bathrooms of fast-food restaurants.

**El Paso, TX:** "Addicts inject heroin in any place immediately available," says the epidemiologic source, "including jails, court bathrooms, public bathrooms, alleys, and side roads...."

Heroin use tends to take place in small group settings, as reported by the majority of epidemiologic/ethnographic and non-methadone treatment sources. Only four epidemiologic and ethnographic sources (in Chicago, Los Angeles, Memphis, and New York) and five non-methadone sources (in Birmingham, Denver, Honolulu, New York, and Philadelphia) perceive that users are more likely to take heroin when alone. By contrast, heroin users in methadone maintenance are more likely to use their drug while alone, as reported by sources in 8 out of 14 sites where this information was provided.

Use contexts are related to demographic variables. For example, the Detroit and Miami epidemiologic sources note that older users tend to take heroin while alone, but younger adults tend to take it in groups or among friends. By contrast, in Baltimore, heroin users increase their social activity and networking as they age.

Being "in the mix"...

According to the Baltimore ethnographic source, "Over the life of their addiction, heroin users tend to increasingly 'be in the mix': they become more networked, more ritualistic in behavior, more involved in social activity, so they can pool resources to purchase drugs or 'do a hustle.'"

How is heroin impacting the health of users? *(Exhibit 11)* Since the last *Pulse Check* reporting period, the impact of heroin use on acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) seems to have stabilized in the majority of non-methadone and methadone programs, except as listed in the table. Any declines are noted in the Northeast, while any increases are noted in the Midwest and South. By contrast, cases of hepatitis C have increased among heroin users in the majority of reporting programs–in many cases because of increased screening, awareness, and early detection. Overdose cases have also increased in numerous programs, especially in the South, and often due to drug mixing. Cases of high-risk pregnancy are generally stable, except as noted.

## HEROIN: THE COMMUNITY

How available is methadone treatment in *Pulse Check* communities? Methadone maintenance is not available at all in Billings or Sioux Falls. In the remaining *Pulse Check* cities, about half of the epidemiologic and ethnographic sources—mainly in the South—consider methadone to be available in selected areas only (in Baltimore, Boston, Columbia, El Paso, Honolulu, Memphis, Miami, New Orleans,

**Exhibit 11.**
**How has heroin use impacted the health of users?**

| | | *Pulse Check* Site | Adverse Impact | Comments |
|---|---|---|---|---|
| Health Consequences | HIV/AIDS | Boston, MA | ↓ | Less needle use and needle sharing; more needle exchange programs, education, snorting other opiates |
| | | Portland, ME | ↓ | Prevention activities having impact |
| | | Philadelphia, PA | ↓ | Clients are tested in the program: 15% positive |
| | | Chicago, IL | ↑ | More AIDS hospitalizations and deaths |
| | | Detroit, MI | ↑ | Not necessarily up in community, but more education causes more HIV+ clients to seek treatment |
| | | Baltimore, MD | ↑ | More criminal justice referrals; more funding sources for social and health care services |
| | | Birmingham, AL | ↑ | More HIV screening; some women resorting to prostitution to get drugs |
| | | Miami, FL | ↑ | Injecting drug use |
| | | Washington, DC | ↑ | More unprotected sex; Prostitutes don't get tested till they reach treatment |
| | Hepatitis C | Boston, MA | ↑ | More screening, diagnosis, early detection; some becoming symptomatic after long time since infection |
| | | New York, NY | ↑ | Users not tested till reach treatment; Mainly unhealthy sex practices |
| | | Portland, ME | ↑ | More injecting drug use |
| | | Baltimore, MD | ↑ | Increasing among criminal justice population |
| | | Birmingham, AL | ↑ | More screening and diagnosis |
| | | Columbia, SC | ↑ | Lack of knowledge; younger users think they are invincible, don't take precautions |
| | | El Paso, TX | ↑ | Long-term exposure to drugs, more body piercing and tattooing |
| | | Memphis, TN | ↑ | Needle sharing |
| | | Miami, FL | ↑ | Injecting drug use |
| | | Washington, DC | ↑ | Testing started at program in November 2000 |
| | | Chicago, IL | ↑ | More testing available this year |
| | | St. Louis, MO | ↑ | Up especially among adolescents and 40+ users who started using in the 1970s; more physician awareness, more testing |
| | | Billings, MT | ↑ | Increased heroin use |
| | | Denver, CO | ↑ | More testing |
| | | Seattle, WA | ↑ | Injecting drug use |
| | Overdose | Detroit, MI | ↓ | Improved access to treatment on demand, so people enter treatment earlier |
| | | Seattle, WA | ↓ | Possibly because fewer juvenile clients (juveniles are most likely to OD) |
| | | Boston, MA | ↑ | Users don't know how pure the drug is |
| | | El Paso, TX | ↑ | Heroin potency up, price down; detox center recently closed; not enough treatment available for increasing demand |
| | | Sioux Falls, SD | ↑ | Increases generally in fall, when students return to college |
| | | Baltimore, MD | ↑ | |
| | | Birmingham, AL | ↑ | Mainly because used in combination with diverted OxyContin® |
| | | Columbia, SC | ↑ | More drug mixing, more copycat drugs (especially ecstasy), more peer pressure |
| | | Memphis, TN | ↑ | Due to interactions with other drugs |
| | | New Orleans, LA | ↑ | Mainly because used in combination with diverted OxyContin® |
| | | Billings, MT | ↑ | |
| | | Honolulu, HI | ↑ | Increasing benzodiazepine use |
| | High-Risk Pregnancy | Los Angeles, CA | ↓ | Because of perinatal program |
| | | Sioux Falls, SD | ↑ | Increase in Native American population, who are more frequently under influence of substances as well as victims of rape by perpetrators under the influence |
| | | Boston, MA | ↑ | Predominantly Hispanics; More risk-taking teenagers, more people taking drugs |
| | | Portland, ME | ↑ | More awareness by medical community |
| | | Columbia, SC | ↑ | Proportion of heroin users up |
| | | Washington, DC | ↑ | More unprotected sex and prostitution |
| | | Billings, MT | ↑ | More pregnant females applying for treatment services |
| | | Honolulu, HI | ↑ | |

*Sources: Non-methadone and methadone treatment providers*

Portland, and Washington, DC), while the other half—mainly in the Midwest and West—consider it to be available throughout their areas.

Waiting lists for admission to public methadone programs are reported by epidemiologic and ethnographic sources in 12 cities, with particularly large numbers reported in Boston (1,000 people) and the longest wait reported in Honolulu (about 3 months). Only three sources report adequate capacity (in Denver, Miami, and New Orleans). In private programs, the majority of epidemiologic and ethnographic sources report adequate capacity, with waiting lists reported only in Birmingham, Columbia, and Miami.

How have methadone treatment availability and capacity changed (fall 2000 vs spring 2001)? Since the last *Pulse Check* reporting period, according to epidemiologic and ethnographic sources, methadone treatment in public programs has declined in Boston and El Paso, become more available in Chicago and somewhat more available in five additional cities (Baltimore, Detroit, Philadelphia, Seattle, and Washington, DC), and has remained stable in eight cities. Private treatment has declined in two cities (Boston and New Orleans), become more available in three cities (Detroit, Memphis, and Seattle), become somewhat more available in two cities (Portland and Birmingham), and remained stable in nine cities.

Slot capacity in public programs has remained stable in eight cities, declined somewhat in El Paso and New Orleans, and increased somewhat in Baltimore, Chicago, Detroit, Philadelphia, Seattle, and Washington, DC. In private programs, capacity has remained stable in 12 cities, increased greatly in Portland (ME), and increased somewhat in Detroit, Memphis, and Seattle.

To what extent is there a methadone diversion problem from programs in *Pulse Check* communities? The majority of law enforcement sources who discussed this question do not consider methadone diversion a problem. It is considered somewhat of a problem, however, by sources in Baltimore, Denver, Los Angeles, and Portland (ME). And sources in Memphis, New Orleans, and Washington, DC, consider diversion to be a serious problem in certain parts of their communities. Since the last *Pulse Check* reporting period, diversion has declined in Portland and St. Louis, increased in Columbia and Memphis, and remained stable elsewhere.

What is the impact of and community reaction to the heroin problem? Recent developments in various *Pulse Check* communities are relevant to the heroin problem and the drug abuse situation in general in a variety of ways:

In the Northeast...

- **Portland, ME:** The epidemiologic source reports on two recent developments in the criminal justice and treatment communities: (1) The drug court program, defunded about 1 year ago, will be starting up again imminently. (2) A satellite of the area's only methadone program (which is private——the area has no public programs) has recently opened, easing some of that program's pressure. Additionally, the local Office of Substance Abuse is considering funding a public detox and methadone maintenance program.

- **New York, NY:** The ethnographic source suggests that police initiatives aimed at street-level drug selling has driven most of the heroin dealers indoors.

- **Philadelphia, PA:** Drug-related deaths have been increasing dramatically, particularly those involving heroin (from 236 heroin toxicology reports in 1999 to 332 in 2000). Additionally, the average number of drugs per death has been increasing.

In the South...

- **Baltimore, MD:** The ethnographic source reports on recent developments in medical consequences, research efforts, law enforcement initiatives, and community collaboration:

  - A dramatic increase in heroin overdoses over the past 9 months has prompted plans for further investigation, via focus groups and other exploratory techniques.

  - Similar to the aggressive law enforcement approach recently used in New York, Baltimore's new mayor and police chief have been adopting the J.Q. Wilson "broken window" model during

the past year: go into a specific neighborhood, put more police on the beat, engage in community relations, establish a law enforcement presence, and prevent that first broken window. It is still too early to gauge whether this strategy has affected crime and the perception of crime.

Baltimore, MD: "The first-of-the-month phenomenon"...

According to the Baltimore ethnographic source, the drug scene, like the general street scene, rotates in a 30-day cycle: it blossoms during the first half of the month, particularly from the first through the eighth day, with more sales, more people on the street, more merchants restocking their shelves, and more business activity in general; then it de-escalates during the second half. Similarly, drug sales, drug-related crime, and drug-related emergency department visits, seem to follow this up-down cycle. One theory to explain this phenomenon is its relation to the compensation cycle: items such as wages, food stamps, welfare, and Social Security checks, tend to be received toward the beginning of the month.

- The Safe and Sound crime prevention effort, targeted at youth, brings together the teams of health professionals and law enforcement officials to address the immediate and specific needs of both victims and assailants.

- **El Paso, TX:** Its unique location, its indigent population, and recent developments make El Paso vulnerable to drug abuse problems, according to the *Pulse Check* epidemiologic source:
  - The only local detox center recently closed, leaving a large gap in services, possibly related to a recent increase in hospital emergencies and deaths.
  - A small grant for hepatitis C testing among indigents, begun in September 2000, has recently yielded a 92-percent-positive rate in injecting drug users (IDUs).
- **Memphis, TN:** Several recent developments are relevant to the local drug abuse situation, according to the epidemiologic source:
  - After a major central city hospital recently closed, drug-related incidents increased in all other local emergency departments.
  - Two ongoing task forces on mental health and substance abuse have recently increased their activities.
  - A recent diversion program focuses on moving misdemeanor drug abusers out of law enforcement and into appropriate health care, such as local emergency departments or detox. Inpatient service can be provided, regardless of ability to pay.

In the West...

- **Seattle, WA:** Current events, social issues, legislative efforts, and drug abuse are intertwined in a variety of ways, according to the *Pulse Check* epidemiologic source:
  - A major international conference on heroin overdoses, held in Seattle in January 2000, spurred a variety of local public activities, such as a joint mayoral/county executive task force that developed recommendations for a variety of approaches to deal with Seattle's long-standing heroin overdose problem.
  - Recent legislation enables the various counties to open new methadone clinics, and many methadone treatment slots are likely to open up over the next year. Another recently introduced bill aims at reducing mandatory sentencing and sending incarcerated drug abusers to treatment before their release.
  - A movement is underway to change the criteria for diverting people to drug court: currently, only users are diverted, while both dealers and "cluckers" (middlemen who "facilitate" connections between the buyers and sellers) are excluded; with the proposed change, both users and cluckers would go to drug court.

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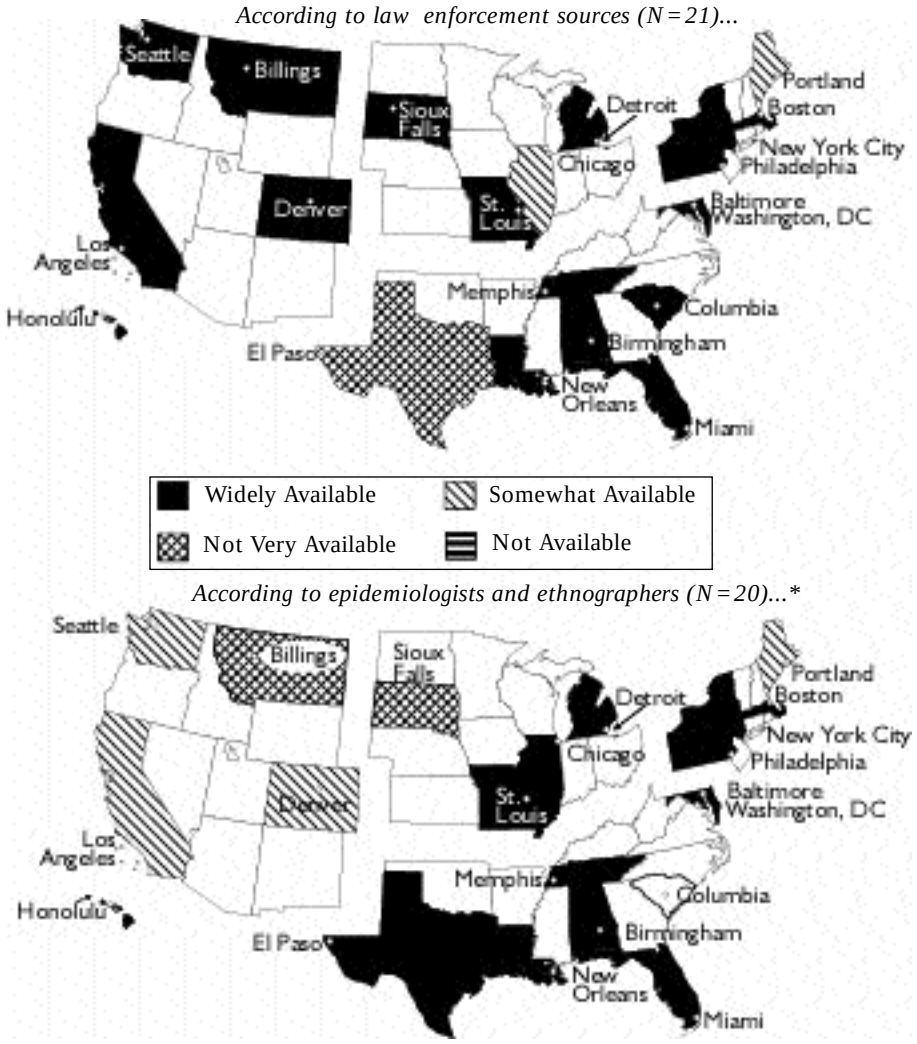
## CRACK: THE PERCEPTION

### How do *Pulse Check* sources perceive the crack cocaine problem in their communities?

Crack is considered the most commonly used drug in *Pulse Check* communities by 20 law enforcement, epidemiologic, ethnographic, and non-methadone treatment sources in 14 cities. As reported in the last *Pulse Check* issue, more than half of those cities are in the South (all eight *Pulse Check* sites in that region). The rest span the remaining regions: the Northeast (New York and Portland, ME); the Midwest (Chicago and Detroit); and the West (Los Angeles, and Seattle). Additionally, the Denver non-methadone treatment source considers both crack and powder cocaine as the most commonly used drugs. Further, crack is considered the second most commonly used drug by sources in Boston, Philadelphia, and St. Louis.

Crack is also named as the drug with the most serious consequences in *Pulse Check* communities by 29 of the 82 sources who provided this information. These sources span 14 cities, and again, more than half are in the South (all 8 *Pulse Check* sites). The rest span the remaining three regions: the Northeast (Boston and New York); the Midwest (Chicago, Detroit, and St. Louis); and the West (Los Angeles). Another two sources (in Baltimore and Philadelphia) name both crack and heroin as the most serious drug problem, while two name cocaine without differentiating between the two types. Crack is named as the drug with the second most serious consequences by 22 additional sources in 16 cities, and it is considered equal to other drugs (in causing the second most serious consequences) in another 5 cities: powder cocaine in Denver and Seattle; heroin in Baltimore and Los Angeles; and benzodiazepines in Philadelphia.

**Exhibit 1.**
**How available is crack cocaine across the 21 *Pulse Check* cities?**




**The epidemiologic source in Columbia, SC, did not provide this information*

### Has the perception of the crack problem changed between fall 2000 and spring 2001?

One source in Memphis believes that crack has overtaken powder cocaine as the most commonly abused drug among hardcore users in the community. However, all other sources who list crack as the most commonly abused drug during the current period report a stable trend since the previous period. Similarly, all but two sources report a stable trend in crack as the drug with the most serious consequences in their communities. El Paso is one exception: that city's epidemiologic source believes that crack has been making inroads and is replacing heroin in terms of serious consequences. Memphis is the other exception, but in reverse: the non-methadone treatment source believes that powder cocaine has overtaken crack in this area.

## CRACK: THE DRUG

**How available is crack cocaine across the country?** *(Exhibit 1)* More than three-quarters (32 of 42) of law enforcement, epidemiologic, and ethnographic *Pulse Check* sources who discussed this question consider crack to be widely available in their community. Only six sources give a "somewhat available" response: three in the West (Denver, Los Angeles, and Seattle); the two sources in Portland, ME; and one source in Chicago. And only three sources, in three different regions, consider it not very available: in Billings, El Paso, and Sioux Falls.

**Has crack availability changed?** *(Exhibit 2)* Crack availability remained stable between fall 2000 and spring 2001, according to the majority of *Pulse Check* sources who discussed this question (17 of 20 law enforcement sources and 14 of 19 epidemiologic and ethnographic sources). Increased availability of crack is reported by only one law enforcement source (in Sioux Falls) and one epidemiologic source (in Seattle). Two law enforcement sources perceive a decline in crack availability (in Chicago and in Portland, ME), as do four epidemiologic and ethnographic sources: two in the West (Denver and Los Angeles), one in the South (El Paso), and one in the Northeast (Portland).

**What are crack cocaine prices across the country?** *(Exhibit 3)* Crack tends to be sold in 0.1 and 0.2 gram rocks, which generally cost approximately $10 and $20, respectively, according to law enforcement, epidemiologic, and ethnographic sources. Gram prices tend to be approximately $100, but prices are as low as $24 in New York and as high as $250 in Honolulu. Purity levels are usually not reported. Nearly all prices are stable in comparison to the last *Pulse Check* reporting period. Two minor changes are reported: the Los Angeles law enforcement source reports some market fluctuation, resulting in a slight increase in the price of some rocks (0.2 gram); and the Seattle epidemiologic source reports a price decline for "kibbles and bits," a unit smaller than the standard rock size (not included in the chart), to $5.

**Exhibit 2.**
**How has crack cocaine availability changed (fall 2000 vs spring 2001)?***


[L] *Law enforcement respondents*
[E] *Epidemiologic/ethnographic respondents*
**The Columbia (SC) epidemiologic and the Memphis law enforcement sources did not provide this information.*

**How and where is crack cocaine made?** Crack continues to be processed locally in most *Pulse Check* communities, as noted in the last issue. In Denver and Portland (ME), however, sources note that it is processed prior to arriving in the community, while in Washington, DC, crack may be processed locally or in New York. Baking soda continues to be the standard ingredient added to powder cocaine to convert it into crack. A few sources, however, mention the use of other adulterants. In New York, for example, the ethnographic source reports vitamin $B_{12}$ and lidocaine. Vitamin $B_{12}$ is also mentioned by the epidemiologic source in Memphis. The Baltimore ethnographic source notes different types of cooking solutions and ammonia as crack cocaine adulterants.

### Do-it-yourself "chemistry"...

The New York ethnographic source notes that "One crack user told a researcher that while a lot of crack is available it is better to buy your own powder cocaine and cook it yourself" (rather than buy ready-made crack) "if you want to get your money's worth. These people refer to themselves as 'chemists.'"

### Crack by bus...

According to the El Paso epidemiologic source, street outreach workers report that some individuals regularly travel by bus between Los Angeles and El Paso for personal reasons and, in the process, also transport crack. Thus, not all of El Paso's crack comes from across the border: some of the supply comes from California.

**Exhibit 3.**
**How much does crack cocaine cost in 19 *Pulse Check* cities?***

| | | MOST COMMON STREET UNIT | | | 1 GRAM | |
|---|---|---|---|---|---|---|
| City | Unit | Size | Price | Purity | Price | Purity |
| *Northeast* | | | | | | |
| Boston, MA | "jum" (small rock) | 0.1 gm | $10 | NR | NR | NR |
| New York, NY | bag | NR | $3–$10 | NR | $24–$30 | 58% |
| | "eightball" | 1/8 oz | $20 | 58% | NR | NR |
| | rock | NR | $7–10 | 58% | | |
| Philadelphia, PA | rock | 0.05–0.1 gm | $5–$10 | 80% | NR | NR |
| Portland, ME | rock | NR | $80 | 75% | NR | NR |
| | "100-rock" | 0.5 gm | $100 | 80% | | |
| *South* | | | | | | |
| Baltimore, MD | vial | NR | $5–$10 | NR | NR | NR |
| Birmingham, AL | rock | 0.2–0.5 gm | $10–$20 | NR | $100 | NR |
| Columbia, SC | rock | 0.2 gm | $20 | NR | $100 | NR |
| | "slab" | 0.5 gm | $100 | NR | | |
| El Paso, TX | rock | 0.25 gm | $20 | NR | NR | NR |
| Memphis, TN | rock | 0.2 gm | $20 | 40–50% | $100 | 40–50% |
| Miami, FL | rock | 0.1 gm | $5–$20 | 80% | NR | 80–90% |
| New Orleans, LA | rock | 0.25 gm | $10 | NR | $40–$50 | NR |
| Washington, DC | "dimebag" | 75 mg | $10 | 30–60% | $80–$100 | NR |
| *Midwest* | | | | | | |
| Chicago, IL | rock | 0.2 gm | $5–$20 | NR | $123 | NR |
| Detroit, MI | rock | 0.1 gm | $10 | 90% | $70–$125 | 90% |
| Sioux Falls, SD | rock | 0.3–0.5 gm | $50 | NR | NR | NR |
| *West* | | | | | | |
| Denver, CO | rock | 0.1–0.2 gm | $20 | 70% | $100–$125 | NR |
| Honolulu, HI | rock | 0.25 gm | $25–$35 | 70% | $100–$250 | NR |
| Los Angeles, CA | rock | 0.2 gm | $20 | NR | $80 | NR |
| Seattle, WA | "20 rock" | 0.1–0.125 gm | $20 | NR | $100 | 40–85% |
| | "40 rock" | 0.2–0.25 gm | $40 | NR | | |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents* **Respondents in Billings and St. Louis did not provide this information.*

**Exhibit 4.**
**How is crack cocaine referred to across different regions of the country?**


*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

How is crack referred to across the country? *(Exhibit 4)* Slang names for crack seem particularly common in the South, with numerous names listed by law enforcement, epidemiologic, and ethnographic sources in all eight *Pulse Check* sites. The majority of the names listed for the Northeast come from Philadelphia. Few slang names are reported by sources in the Midwest and the West.

How is crack packaged and marketed? The New York ethnographic source reports that small glassine bags and light plastic wrap

knotted at both ends are replacing plastic colored vials as the preferred method of packaging crack cocaine. The Portland, ME, law enforcement source mentions a similar packaging: a plastic bag whose corner is knotted in "Dominican ties." Elsewhere, packaging remains relatively unchanged since the last *Pulse Check* reporting period. The most commonly reported packaging, as in the case of heroin, remains small plastic, cellophane, glassine, or coin bags, often the "zipper" type, particularly throughout the Northeast, the South, and the Midwest. In the West, however, that packaging is reported only in Honolulu. Other types of packaging are more common in that region: plastic or glass vials (as reported in Denver, Los Angeles, and Seattle); foldover bindles of plastic, paper, or magazine pages (as reported in Billings, Denver, Honolulu, Los Angeles, and Seattle); plastic wrap or cellophane (in Denver, Honolulu, and Los Angeles); foil (in Los Angeles and Seattle); plastic balloons (in Los Angeles); and just loose rocks (in Seattle). Loose rocks are mentioned most frequently in the South (Birmingham, Columbia, Memphis, Miami, New Orleans, and Washington, DC), but are also found in the Northeast (in Boston and New York) and the Midwest (Detroit and St. Louis). Baltimore is the only *Pulse Check* city outside of the West where sources report crack sold in vials. According to that city's ethnographic source, different neighborhoods use different colors on the crack vial tops for identification: "The vial tops are red on Monroe Street, but blue on East Baltimore...." Elsewhere in the South, the El Paso law enforcement source reports balloon packaging and paper diamond folds—similar to packaging found nearby in the West.

## CRACK: THE SELLERS

**How are crack cocaine sellers organized?** According to law enforcement sources, crack sellers in all four *Pulse Check* cities in the Northeast operate independently. Recently, however, gangs have started taking over sales in New York. In the South, by contrast, sales structures vary: independent operations are reported in Baltimore, El Paso, Miami, and Washington, DC; both types of sales structures—independent and organized—are reported in Birmingham and New Orleans; and loosely organized structures or small networks are reported in Columbia (SC) and Memphis. Sales structures also vary in the Midwest: operations are organized in Chicago and (loosely) in Sioux Falls, while both independent and organized structures are reported in Detroit and St. Louis. Similarly, in the West, sales structures vary, from organized in Billings, Denver, and Seattle to independently run operations in Honolulu, to a mix of structures in Los Angeles.

By contrast, nearly all epidemiologic and ethnographic sources who provide this information report that crack sellers are affiliated with organized sales structures, such as gangs. As is the case with heroin, this seeming discrepancy might be explained by differing definitions of what constitutes an organized group.

**Then and Now:**

**How have crack sellers and sales changed across the country (fall 2000 vs spring 2001)?**

*The crack sales scene has remained relatively stable since the last* Pulse Check *report. Only a handful of changes are reported, with no discernible regional trends:*

| | |
|---|---|
| **Baltimore, MD; Birmingham, AL; Columbia, SC; and Memphis, TN:** | ➤ Law enforcement sources note a tendency toward younger crack sellers. |
| **Boston, MA:** | ➤ Continuing a trend noted in the last issue of *Pulse Check*, crack sales are increasingly moving indoors, with more deliveries made via beeper orders. The Boston ethnographic source attributes this phenomenon to increased law enforcement efforts and to urban renewal. |
| **Denver, CO:** | ➤ Sales are starting to take place in the suburbs, according to the law enforcement source. |
| **Los Angeles, CA:** | ➤ The law enforcement source notes that electronic equipment, such as cell phones, continues to be increasingly involved in crack sales. |
| **New York, NY:** | ➤ The law enforcement source reports that gangs have recently started taking over sales. |
| **St. Louis, MO:** | ➤ According to the epidemiologic source, crack used to come into the area from Colombia through Mexico, but now more seems to be coming directly from Mexico. |

### How is street-level crack sold?

Hand-to-hand crack sales are reported by law enforcement sources in every *Pulse Check* city, as noted in the last *Pulse Check*, and similar to the most common method for selling heroin. Sales involving beepers or cell phones are also quite common—reported by law enforcement sources in 16 cities: all four *Pulse Check* sites in the Midwest, all but one (Washington, DC) of the sites in the South, all but one (Seattle) in the West, and New York in the Northeast. Acquaintance networks are mentioned in 13 cities, and home delivery (which often also involves beeper or cell phone use) is mentioned in 11. Internet sales are reported in New York.

Epidemiologic and ethnographic sources, similarly, report that hand-to-hand sales are the most common (in 14 cities), followed by beeper/cell phone sales (in 10 cities), then by home delivery and acquaintance networks (in 7 cities each). In El Paso, crack is also reportedly sold over the Internet.

### How old are street-level crack sellers?

As reported in the last *Pulse Check* issue, young adults (18–30 years) continue to be the predominant crack sellers at the street level, according to law enforcement sources in nearly every city. Several exceptions, however, are noteworthy. In the Northeast, for example, older adults are more likely to sell crack in Philadelphia. In the South, adolescents are the primary sellers in Baltimore, while all three age groups (adolescents, young adults, and older adults) are equally likely to sell crack in Memphis. In the Midwest, both young and older adults are named as the primary crack sellers in Sioux Falls and St. Louis. And in the West, all three age groups are listed for Denver, while adolescents reportedly predominate in Seattle crack sales. In comparing the fall 2000 and spring 20001 reporting periods, four law enforcement sources—all in the South—note a tendency toward younger crack sellers: in Baltimore, Birmingham, Columbia (SC), and Memphis.

Epidemiologic and ethnographic sources concur that young adults are the most likely to sell crack, as reported in nearly every city where this information was provided. Five exceptions, however, are noted in the South and the Midwest: young adults and adolescents are equally likely to be the primary crack sellers in Birmingham and Detroit; young adults and older adults are equally likely in Memphis; and adolescents are considered the predominant seller group in Baltimore and Chicago. Adolescents are also noted, to a lesser extent, as sellers in other cities. In New York, for example, the ethnographic source reports that "some dealers in Manhattan are as young as 13."

### What other drugs do crack dealers sell?

*(Exhibit 5)* As reported in previous issues of *Pulse Check*, crack dealers are often polydrug sellers. In New York, law enforcement, epidemiologic, and ethnographic sources report that some dealers sell as many

**Exhibit 5.**
**What other drugs do crack dealers sell?***

| | City | Marijuana | | Powder Cocaine | | Heroin | | Methamphetamine | | Ecstasy | | No Other Drugs Sold | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | LE | E | LE | E | LE | E | LE | E | LE | E | LE | E |
| Northeast | Boston, MA | | | | | | | | | | | ✓ | ✓ |
| | New York, NY | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | | |
| | Philadelphia, PA | | | | | | | | | | | ✓ | |
| | Portland, ME | ✓ | | | | ✓ | | | | | | | |
| South | Baltimore, MD | | ✓ | | | | | | | | | ✓ | |
| | Birmingham, AL | ✓ | | ✓ | | | | | | | | | ✓ |
| | Columbia, SC | ✓ | | ✓ | | | | | | | | | |
| | El Paso, TX | | | | | | | | | | | ✓ | |
| | Memphis, TN | | | | | | ✓ | | | | | ✓ | |
| | Miami, FL | | | ✓ | | | | | | | | | ✓ |
| | New Orleans, LA | | ✓ | ✓ | | ✓ | ✓ | | | | | | |
| | Washington, DC | ✓ | | | | | | | | | | | |
| Midwest | Chicago, IL | | | | ✓ | | ✓ | | | | | ✓ | |
| | Detroit, MI | ✓ | ✓ | | | ✓ | ✓ | | | | | | |
| | St. Louis, MO | ✓ | ✓ | | | | ✓ | | | | | | |
| | Sioux Falls, SD | ✓ | | | | | | | | | | | |
| West | Billings, MT | | | ✓ | | | | ✓ | | | | | |
| | Denver, CO | | | | | | | | | | | ✓ | |
| | Honolulu, HI | | | | | | | ✓ | | | | | |
| | Los Angeles, CA | | | | | | | | | | | ✓ | |
| | Seattle, WA | ✓ | | | | ✓ | | | | | | | |

*Sources: Law enforcement (LE), epidemiologic, and ethnographic (E) respondents*
**Epidemiologic sources in Billings, Columbia, El Paso, Denver, Honolulu, Los Angeles, Philadelphia, Portland, Seattle, Sioux Falls, and Washington, DC, did not provide this information*

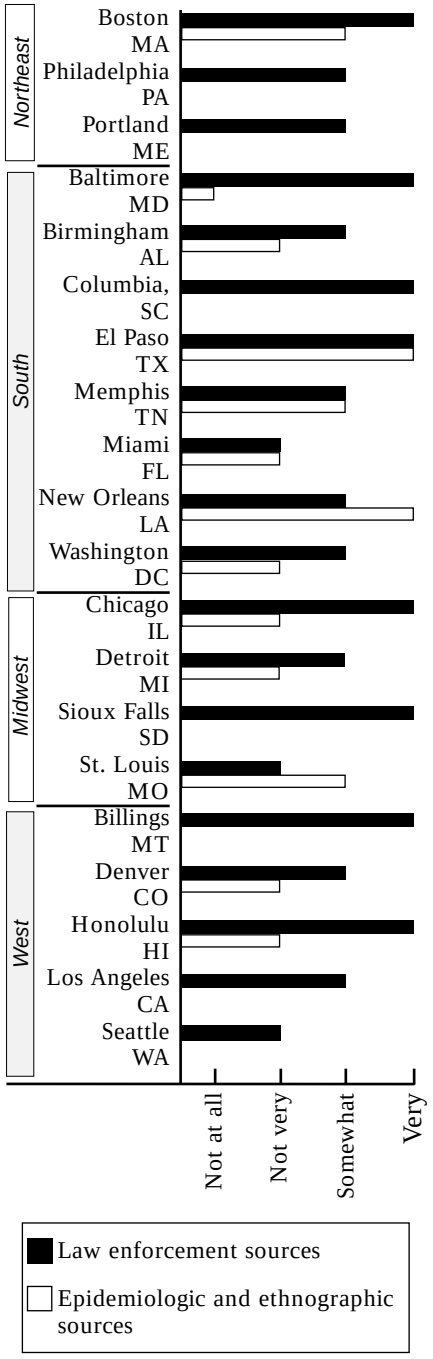
as four drugs in addition to crack. Other "one-stop shops," where dealers sell two or three drugs in addition to crack, are particularly common in the South (Birmingham, Columbia, and New Orleans) and the Midwest (Chicago, Detroit, and St. Louis); they are less commonly reported in the Northeast (Portland, ME) and the West (Billings and Seattle). Overall, marijuana is reported in 11 cities, followed by heroin (in 8 cities) and powder cocaine (in 7 cities). Methamphetamine is mentioned in only two western sites, and ecstasy is named only in New York. Eight law enforcement sources and three epidemiologic and ethnographic sources, however, report that crack sellers in their communities sell no other drugs.

One-stop shopping...

In some cities, such as St. Louis—as noted by that city's epidemiologic source—crack dealers affiliated with gangs are the ones most likely to run a "one-stop shop," selling multiple drugs.

Do crack sellers use their own drug? *(Exhibit 6)* In Miami, St. Louis, and Seattle, crack sellers usually do not use the product they sell, according to law enforcement sources. In all other *Pulse Check* sites, sellers are somewhat or very likely to use their own drug. Epidemiologic and ethnographic sources, however, generally consider crack sellers as less likely to use their own drug. Only in Boston, El Paso, Memphis, New Orleans, and St. Louis do these sources describe crack dealers as very or somewhat likely to use crack themselves. The Boston ethnographic source adds that "nearly all users eventually sell" and that "older sellers are selling to make enough to 'hustle' their own crack," but that "a few of the dealers are younger, in gangs, and less likely to use." Nearly all the remaining epidemiologic and ethnographic sources who addressed this issue believe that crack sellers are not very likely to use crack. Furthermore, in Baltimore, the ethnographic source reports that sellers, who are predominantly adolescents, do not use crack.

**Exhibit 6.**
**How likely are crack sellers to use their own drug?***




*Sources: Law enforcement, epidemiologic, and ethnologic respondents*
**The law enforcement source from New York and the epidemiologic sources from Billings, Columbia, Los Angeles, New York, Philadelphia, Portland, Seattle, and Sioux Falls did not provide this information.*

What type of crimes are crack sellers involved in? All law enforcement sources consider crack sellers as somewhat or very likely to be involved in other criminal activity. The majority name both violent and nonviolent crimes (15 and 16 sources, respectively, out of 21). The most commonly mentioned crime is gang-related activity, as noted by 13 sources, heavily concentrated in the South (in Baltimore, Birmingham, Columbia, Memphis, New Orleans, and Washington, DC) and the West (in Denver, Honolulu, Los Angeles, and Seattle), and to a lesser extent in the Northeast (in Boston) and the Midwest (in Chicago and St. Louis). Prostitution is also mentioned frequently, again particularly in the South (Birmingham, Columbia, El Paso, New Orleans, and Washington, DC), and to a lesser extent elsewhere (Boston and Philadelphia in the Northeast; St. Louis in the Midwest; and Denver and Honolulu in the West). Domestic violence is noted in six cities (Baltimore, Birmingham, Boston, Denver, Memphis, and St. Louis). Other crimes specified include theft and burglary (in Billings and Chicago), robberies and shootings involving other dealers (in Columbia, SC), and money laundering (in Detroit).

**Exhibit 6. Where is street-level crack cocaine sold and used?***

| | City | Street | | Crack Houses | | Public Housing | | Private Housing | | Inside Cars | | Parties | | Parks | | Schools | | Clubs | | College | | Raves | | Shopping Malls | | Supermarkets | | Internet | # of Settings | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | S | U | S | U | S | U | S | U | S | U | S | U | S | U | S | U | S | U | S | U | S | U | S | U | S | U | S | U |
| Northeast | Boston, MA | ✓ | | ✓ | | ✓ | | | | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | | | | | | | 7 | NR |
| | New York, NY | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | 14 | 6 |
| | Philadelphia, PA | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | ✓ | | | | | | | | | | | | | 5 | 6 |
| | Portland, ME | ✓ | | | | | ✓ | | ✓ | ✓ | | | | | | | | | | | | ✓ | | | | | | | 3 | 2 |
| South | Baltimore, MD | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | | ✓ | | 10 | 12 |
| | Birmingham, AL | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | 13 | 5 |
| | Columbia, SC | ✓ | | ✓ | | ✓ | | | | ✓ | | | | | | | | ✓ | | | | | | | | | | | 5 | NR |
| | El Paso, TX | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | 13 | 12 |
| | Memphis, TN | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | 14 | 6 |
| | Miami, FL | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | | | 11 | 3 |
| | New Orleans, LA | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | 12 | 8 |
| | Washington, DC | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | | ✓ | | | | ✓ | | | | | | | | | 4 | 8 |
| Midwest | Chicago, IL | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | | | | ✓ | | | | | 11 | 6 |
| | Detroit, MI | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | 11 | 6 |
| | St. Louis, MO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | | | | | ✓ | | | | | 9 | 6 |
| | Sioux Falls, SD | ✓ | | | ✓ | ✓ | | | ✓ | ✓ | | | ✓ | | | | | ✓ | | | | | | | | | | | 4 | 2 |
| West | Billings, MT | ✓ | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | 13 | 2 |
| | Denver, CO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | | | | | | | | 9 | 6 |
| | Honolulu, HI | ✓ | | | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | 14 | 1 |
| | Los Angeles, CA | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | ✓ | | | | | | | | | | | | | | 3 | 6 |
| | Seattle, WA | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | | | | | | 6 | 10 |

*S = Sell U = Use*
*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
**The epidemiologic/ethnographic sources in Billings, Boston, Columbia, Los Angeles, Seattle, and Sioux Falls did not provide seller setting information. The Columbia epidemiologic/ethnographic source did not provide user setting information. The Boston source for user setting responded, "most private setting available."*

## Where is crack cocaine sold?

*(Exhibit 7)* All but 6 of the 21 law enforcement sources agree that crack sales generally take place in central city areas. Five of those six exceptions are in the South. In Miami and New Orleans, crack is equally likely to be sold in central city and suburban areas. In El Paso, crack sales are more likely to occur in the suburbs. In Birmingham, Memphis, and—outside of the South—New York, crack is sold in a wide range of areas, including central city, suburban, and rural areas. The locations for crack sales remain the same since the last *Pulse Check* reporting period, except for Denver, where crack sales have expanded to suburban areas, according to the law enforcement source.

Similarly, nearly every epidemiologic and ethnographic source who provided this information indicates that crack is sold primarily in central city areas. In Birmingham and El Paso, however, it is sold both in central city and rural areas. And in Detroit, crack is sold in central city, rural, and suburban areas.

Both outdoor and indoor sales occur across sites, with a few exceptions. According to law enforcement sources, outdoor sales are more common in Chicago and Philadelphia while indoor sales predominate in Baltimore. According to epidemiologic and ethnographic sources, indoor sources are more common in Detroit while outdoor sales predominate in Washington, DC.

The specific settings for crack sales, like for heroin sales, are varied. Public housing developments, cars, and crack houses are mentioned by law enforcement, epidemiologic, or ethnographic sources in nearly every city. Parties and schools are the next most common settings, followed by parks, private housing, and clubs. College campuses and raves are also mentioned in at least half the sites, while sales in shopping malls, outside supermarkets, and over the Internet are mentioned in some cities. Overall, several cities have a particularly wide range of crack sales settings.

## CRACK: THE USERS

How old are crack cocaine users? *(Exhibit 8)* Epidemiologic and ethnographic sources vary in their views of which age groups are most likely to use crack. Three (in Boston, Birmingham, and Detroit) consider both young adults (18–30 years) and older adults (older than 30 years) equally likely to use the drug, although in Birmingham, crack use among young adults has declined. Young adults are considered the primary user group in nine *Pulse Check* cities: Philadelphia in the Northeast; Baltimore, El Paso, and New Orleans in the South; St. Louis and Sioux Falls in the Midwest; and Billings, Honolulu, and Seattle in the West. Older adults are named in eight cities: Portland, ME, in the Northeast; Columbia, Memphis, Miami, and Washington, DC, in the South; Chicago in the Midwest; and Denver and Los Angeles in the West. In Washington, DC, however, while older adults remain the primary user group, use among younger adults is increasing. These findings differ from those in the last *Pulse Check* issue, when epidemiologic and ethnographic sources named older adults as the group likeliest to use crack in all but four cities (Birmingham, Honolulu, Los Angeles, and Sioux Falls).

All reporting *Pulse Check* treatment sources note that the age of crack users in treatment has remained stable. The non-methadone treatment providers are more likely to report younger adults (18–30 years) than older adults (>30 years) as the predominant crack users. Both age groups are considered equally likely to use crack in three cities: Birmingham, Memphis, and Philadelphia. The younger adult group is named in

**Then and Now:**

**How have crack cocaine users changed across the country (fall 2000 vs spring 2001)?**

**According to epidemiologic and ethnographic sources...**

*Crack use has remained relatively stable since the last* Pulse Check *reporting period. Only a few changes are reported among young adults, among Hispanics, among women, and in where crack users reside:*

| | |
|---|---|
| ***Among young adults:*** | ➤ **Birmingham, AL:** Crack use has declined among young adults (18–30 years), who are now as likely to use the drug as older adults (>30 years).<br>➤ **Washington, DC:** Crack use has increased among younger adults, but older adults remain most likely to use the drug. |
| ***Among Hispanics:*** | ➤ **Columbia, SC:** A small increase in the number of Hispanics using crack reflects a similar increase in the overall population. The numbers, however, remain small.<br>➤ **Philadelphia, PA:** Hispanics, who are overrepresented among crack users, have increased in proportion since the last *Pulse Check* report. |
| ***Among women:*** | ➤ **Columbia, SC:** The percentage of females among crack users has been fluctuating during the past 12 months (between 38 and 56 percent), with no particular pattern.<br>➤ **St. Louis, MO:** While crack users are still predominantly males (approximately 60 percent), the number of female users has been increasing over the past 5 or 6 years. |
| ***Where crack users reside:*** | ➤ **St. Louis, MO:** With the mass exodus from the city into the surrounding counties over the past few years, the crack problem is becoming more concentrated among people of lower SES, who remain in the city.<br>➤ **Washington, DC:** Crack users continue to reside primarily in the central city, but increases are noted among suburban dwellers. |

***According to treatment sources...***

| | |
|---|---|
| *Crack user demographic characteristics and use patterns have remained stable since the last* Pulse Check *reporting period, with only a few exceptions:* | ➤ **Novice use:** Recent initiation of crack use by any drug treatment client has increased in only four non-methadone programs (in Billings, Memphis, Portland, and Sioux Falls) and one methadone program (in Columbia, SC).<br>➤ **Female use:** The Washington, DC, non-methadone provider notes an increase in females smoking crack. |

**Exhibit 8.**
**What age group is most likely to use crack?**

| | Adolescents (<18) | Young Adults (18–30) | Adults (>30) |
|---|---|---|---|
| Northeast | | Boston, MA[E,N,M]<br>Philadelphia, PA[E,N,M]<br>Portland, ME[N] | Boston, MA[E,M]<br>Philadelphia, PA[N]<br>Portland, ME[E] |
| South | Columbia, SC[N] | Baltimore, MD[E]<br>Birmingham, AL[E,N]<br>Columbia, SC[M]<br>El Paso, TX[E,N]<br>Memphis, TN[N]<br>Miami, FL[N]<br>New Orleans, LA[E,N,M]<br>Washington, DC[N] | Baltimore, MD[N]<br>Birmingham, AL[E,N,M]<br>Columbia, SC[E]<br>Memphis, TN[E,N]<br>Miami, FL[E]<br>Washington, DC[E,M] |
| Midwest | Sioux Falls, SD[N] | Chicago, IL[N]<br>Detroit, MI[E,N]<br>St. Louis, MO[E]<br>Sioux Falls, SD[E] | Chicago, IL[E,M]<br>Detroit, MI[E,M]<br>St. Louis, MO[N]<br>Sioux Falls, SD[N] |
| West | Los Angeles, CA[N] | Billings, MT[E]<br>Honolulu, HI[E,N]<br>Los Angeles, CA[N]<br>Seattle, WA[E,N] | Denver, CO[E,N]<br>Honolulu, HI[M]<br>Los Angeles, CA[E,M]<br>Seattle, WA[ME] |

[E] *Epidemiologic/ethnographic respondents* [N] *Non-methadone treatment respondents*
[M] *Methadone treatment respondents*

11 cities: Boston and Portland in the Northeast; El Paso, Miami, New Orleans, and Washington, DC, in the South; Chicago and Detroit in the Midwest; and Honolulu, Los Angeles, and Seattle in the West. Older adults, exclusively, are named in only two cities: Baltimore and Denver. Most disturbingly, adolescents (younger than 18) are the largest crack-using group in the Columbia, SC, non-methadone program, and they share the dubious number-one spot with young adults in Los Angeles, and with older adults in Sioux Falls.

By contrast, crack-using clients in the methadone programs appear older than those in the non-methadone programs: nearly all responding *Pulse Check* sources in this category report that any clients who use crack tend to be in the older adult (>30 years) category. This finding, similar to findings about heroin-using clients, is not surprising because methadone maintenance tends to involve people who have been treated over a long period of time. The only exceptions are in Boston, Philadelphia, Columbia (SC), and New Orleans programs, where the younger adults outnumber the older adults among crack users in methadone maintenance.

### Are there any gender differences in who uses crack? *(Exhibit 9)*

According to the New York ethnographic source, females are the predominant crack users in that city. Moreover, females and males are evenly split among crack users according to epidemiologic and ethnographic sources in nine *Pulse Check* cities: Chicago and Sioux Falls in the Midwest; Boston and Philadelphia in the Northeast; Baltimore, Columbia, Miami, and Washington, DC, in the South; and Seattle in the West. The remaining 11 epidemiologic and ethnographic sources report males as the predominant crack users in their respective cities. In St. Louis, while crack users are still predominantly males (approximately 60 percent), the number of female users has been increasing over the past 5 or 6 years.

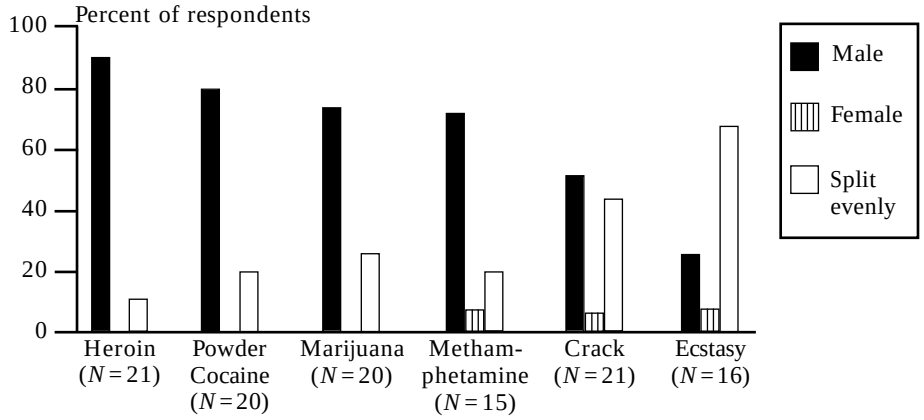
### What drugs do female users tend to take?

The Boston ethnographic source comments that "females are more likely to use crack than IV drugs such as heroin and powder cocaine." Indeed, as Exhibit 9 shows, epidemiologic and ethnographic sources tend to consider females as equally or more likely than males to use crack, more so than any other illicit drug except ecstasy.

Non-methadone treatment sources, like epidemiologic and ethnographic sources, report an even gender split among crack-using clients in several *Pulse Check* cities: Philadelphia in the Northeast; Washington, DC, in the South; Sioux Falls and St. Louis in the Midwest; and Billings, Honolulu, Los Angeles, and Seattle in the West. Males are the predominant crack users among clients in the remaining non-methadone treatment programs. The only reported change is in Washington, DC, where more females are smoking crack than ever before.

Only four methadone treatment providers report males as predominant among crack users in their programs: in Birmingham, Boston,

**Exhibit 9. Which genders are the predominant users of specific drugs in the 21 *Pulse Check* cities?**




*Source: Epidemiologic and ethnographic respondents*

New Orleans, and Seattle. Both males and females are equally likely to use crack in another five methadone programs (in Boston, Columbia, Detroit, Los Angeles, and Washington, DC). Females comprise the majority of crack-using clients in the Chicago and Honolulu methadone programs. Eight methadone sources, however, did not supply breakdowns of their client population by gender.

Is any racial/ethnic group more likely to use crack? *(Exhibit 10)* According to epidemiologic and ethnographic sources, Blacks account for the largest proportion of crack users in 11 of the 21 *Pulse Check* cities, where they are overrepresented relative to the general population. In Birmingham, Blacks and Whites are equally likely to use crack, reflecting their distributions in the general population. El Paso has two distinct racial/ethnic groups of crack users: Blacks are the predominant sole crack users; but Hispanics are the most likely to use both crack and heroin. Whites are more likely than other racial/ethnic groups to use crack in seven cities and are overrepresented relative to the general population in three of those cities. Only two race/ethnicity changes are reported: in Philadelphia, Hispanics, who are overrepresented among crack users, have increased in proportion since the last report; and in Columbia, SC, a small increase in the number of Hispanics using crack (which remains small) reflects a similar increase in the overall population.

White crack users in Boston?

"The majority of crack users are Black," states Boston's ethnographic source. "White crack users tend to be heroin addicts who are losing injectable surface veins."

According to *Pulse Check* treatment sources, Blacks are the predominant crack users among clients in 11 non-methadone programs but only 5 methadone programs. Whites account for the largest proportions of crack users at four non-methadone programs and six methadone programs. Blacks and Whites are split approximately evenly as the foremost crack users in the Columbia, SC, methadone program, while Blacks, Whites, and Hispanics are about equally represented at three non-methadone programs: in El Paso, Los Angeles, and Philadelphia. No racial/ethnic shifts are reported by any treatment sources since the last *Pulse Check* reporting period.

What is the most common socioeconomic background of crack users? Crack-using populations are predominantly in lower SES categories in all but 4 of the 21 cities, according to epidemiologic and

**Exhibit 10.**
**What racial/ethnic group is most likely to use crack?**

| | City | Crack | | |
|---|---|---|---|---|
| | | E | N | M |
| *Northeast* | Boston, MA | **Black** | White | **White** |
| | New York, NY | NR | NR | NR |
| | Philadelphia, PA | **Black** | All | Black |
| | Portland, ME | **White** | White | NR |
| *South* | Baltimore, MD | **Black** | Black | Black |
| | Birmingham, AL | Black/ White | **Black** | Black |
| | Columbia, SC | **Black** | **White** | Black/ White |
| | El Paso, TX | Black | All | NR |
| | Memphis, TN | **White** | Black | NR |
| | Miami, FL | **Black** | **Black** | NR |
| | New Orleans, LA | **Black** | Black | White |
| | Washington, DC | **Black** | Black | Black |
| *Midwest* | Chicago, IL | **Black** | Black | Black |
| | Detroit, MI | White | **Black** | Black |
| | St. Louis, MO | **Black** | **Black** | NR |
| | Sioux Falls, SD | White | Black | N/A |
| *West* | Billings, MT | **White** | White/ Ameri-can Indian | N/A |
| | Denver, CO | White | **Black** | Black |
| | Honolulu, HI | **White** | NR | White |
| | Los Angeles, CA | **Black** | All | White |
| | Seattle, WA | **Black** | White | White |

*Sources: Epidemiologic/ethnographic (E), non-methadone treatment (N), and methadone treatment (M) respondents*
*Note: Shaded boxes indicate that a given drug-using population is overrepresented relative to that city's general population. Not all sources, however, had this information available.*

ethnographic sources. In Honolulu and Sioux Falls, crack users are primarily middle SES; in Birmingham, they are both lower and middle SES; and in Detroit, users cross all SES categories. Treatment sources concur that crack users are generally found in the lower SES groups. The only exceptions are in Boston, Columbia (SC), Honolulu, Los Angeles, New Orleans, and Sioux Falls, where either the middle SES or both lower and middle SES groups are cited by treatment providers.

### Crack in St. Louis: Increasingly a lower SES problem...

As the St. Louis epidemiologic source notes, "With the mass exodus from the city into the surrounding counties over the past few years, St. Louis' crack problem is becoming more concentrated among people of lower SES, who remain in the city."

**Where do crack users tend to reside?** Crack users reside primarily in central city areas, as reported by nearly all (18 of the 21) epidemiologic and ethnographic sources. In El Paso and Sioux Falls, however, crack users are more likely to reside in the suburbs, while in Detroit users reside throughout the area. While Birmingham's crack users reside primarily in the central city, the epidemiologic source notes that many users reside throughout small rural towns all over Alabama.

Similarly, all but three treatment sources report that the majority of crack users reside in central city areas. Two exceptions are in Sioux Falls, where crack users in the two non-methadone *Pulse Check* sites are more likely to live in rural areas. Seattle is the third exception, with crack users equally likely to reside in both central city and suburban locations. Additionally, smaller populations of crack users reside in the suburban and rural areas surrounding Honolulu and St. Louis, as reported by those cities' methadone and non-methadone treatment sources, respectively.

### How do crack cocaine users wind up in treatment?

As reported in the last *Pulse Check* issue, courts and the criminal justice system remain the most common referral sources for clients entering treatment for crack addiction, according to the responding treatment sources. Individual referrals, again, follow closely as the second most common referral source.

**How do users take crack?** Smoking, by far, remains the predominant route of crack administration in every *Pulse Check* city, according to all epidemiologic and ethnographic sources and nearly all treatment sources. The only exceptions are in three non-methadone treatment programs: in Boston, injecting equals smoking; in Memphis, snorting predominates; and in Sioux Falls, both snorting and smoking are common. Occasional crack injection is also mentioned by epidemiologic and ethnographic sources in Baltimore (where solid crack is sometimes cooked and injected), New Orleans (where crack is injected with heroin in speedballs), and Washington, DC (where it is injected with heroin and marijuana).

**Then and Now:**

**How have crack cocaine use patterns changed across the country (fall 2000 vs spring 2001)?**

***According to epidemiologic and ethnographic sources...***

| | |
|---|---|
| ***Increased crack injection:*** | ➤ **Baltimore, MD:** Solid crack is sometimes cooked and injected, according to recent reports.<br>➤ **Washington, DC:** Crack is being injected with heroin and marijuana. |
| ***More drugs:*** | ➤ **Philadelphia, PA:** Crack users are taking a wider range of other drugs than before, including heroin, marijuana, ecstasy, and diverted prescription drugs such as alprazolam (Xanax®), diazepam, amitriptyline (Elavil®), and, most recently, oxycodone (OxyContin®). |
| ***Decline in crack houses:*** | ➤ **Denver, CO:** Crack houses have become less prominent, but this change is long term, rather than recent.<br>➤ **St. Louis, MO:** Crack houses have become less prominent, possibly because cell phones and beepers are increasingly used and because users know which blocks to drive down in order to make their "connections." |
| ***Increased public use:*** | ➤ **Seattle, WA:** Public smoking of crack has increased since the last report. Users are now equally likely to smoke the drug either in public or in private. |

How frequently do users take crack? The majority of non-methadone treatment sources (15 of 21) report that crack users in their program tend to take the drug daily. Less frequent usage is reported in six programs, three of which are in mid-western *Pulse Check* cities: Chicago (four to seven times a week), Columbia (SC) (once to twice a month), Los Angeles (twice a month), Portland (ME) (three to four times a week), St. Louis (three to four times a week), and Sioux Falls (once to twice a month). In methadone programs, by comparison, usage frequency appears lower: only seven *Pulse Check* sources report daily crack usage by clients in their programs, while another seven report less than daily use. In Philadelphia, for example, some clients use crack daily, but binge use is more typical.

What other drugs do crack users take? Aside from alcohol, the substances most commonly consumed with crack—either sequentially or in combination—are marijuana and heroin. Marijuana is mentioned by epidemiologic, ethnographic, and treatment sources across the country: Philadelphia in the Northeast; Baltimore, Birmingham, Columbia, Miami, New Orleans, and Washington, DC, in the South; Detroit and St. Louis in the Midwest; and Denver, Honolulu, and Seattle in the West. Heroin is also mentioned by the same source categories in all four regions: Boston, New York, Philadelphia, and Portland in the Northeast; El Paso, Memphis, New Orleans, and Washington, DC, in the South; only Chicago in the Midwest; and Denver, Honolulu, and Los Angeles in the West.

The marijuana-crack combination (in a blunt) in Philadelphia is known as a "diablito" or a "turbo." That city's epidemiologic source also lists a variety of diverted prescription drugs abused by crack users, including alprazolam and diazepam (benzodiazepines); amitriptyline (an antidepressant); and oxycodone (the opiate in Percodan®, Percocet®, and OxyContin®). The New York ethnographic source similarly mentions the crack-diazepam combination, stating that "A woman in the Bronx told a researcher that when she cooked up her crack she would put 'a valium' in it. She said when she smoked this crack combination it felt like she was using heroin." New York users also combine crack with PCP, a practice known as "space basing." Further south, alprazolam and diazepam are also commonly taken by crack users in Memphis, according to the epidemiologic source. In the West, three treatment sources—in Billings, Honolulu, and Los Angeles—report that crack users in their programs also abuse diverted benzodiazepines, such as diazepam and clonazepam. The Los Angeles methadone treatment source adds that some crack-using clients also abuse the diverted prescription muscle relaxant carisoprodol (Soma®).

Where and with whom is crack used? *(Exhibit 7)* Unlike crack sales, which occur both indoors and outdoors, crack use is more likely to take place indoors than outdoors (according to 12 out of 20 responding epidemiologic and ethnographic sources). Users also prefer to smoke crack in private, rather than public (13 out of 20 sources) and in small groups or among friends, rather than while alone (11 out of 20 sources).

Nearly all the remaining epidemiologic and ethnographic sources report that sales and use occur both indoors and outdoors and in both private and public locations. But sources in six cities (Baltimore, Los Angeles, Memphis, Miami, New York, and Portland) report that crack users tend to use their drug while alone, rather than in a group. The Baltimore ethnographic source explains that "crack users tend to smoke their drug alone, not in groups, because of the short duration of the high." Baltimore is also the only city where outdoor use is slightly more common than indoor use, but the ethnographic source notes a particularly wide range of use settings, including "abandominiums" (abandoned row houses) and fast-food restaurant bathrooms. Similarly, the El Paso epidemiologic source lists a particularly wide range of use settings. El Paso is also the only city where use in public places is more common than use in private locations.

Overall, a wide variety of specific settings are reported, with private residences most commonly mentioned, followed by crack houses and public housing developments. Crack houses, however, are becoming less prominent in some areas, such as Denver and St. Louis. Other venues mentioned, in descending order of frequency, include parties, cars, nightclubs, schools, and college campuses. The Honolulu epidemiologic source adds two other unusual crack use settings: adult video galleries, and hotel rooms.

Treatment sources concur that crack is usually used indoors, in private, and in small groups or among friends. Outdoor use is more common than indoor use in only two programs (the Boston and Columbia [SC]

### Indoor versus outdoor crack use in Boston...

Outdoor use in Boston, while slightly less common than indoor use, is still widespread. As that city's ethnographic source points out, "crack is used outdoors more than other drugs because it's easier to 'do' without being seen." By contrast, a Boston treatment source states that "crack can't be used in public because of its distinct odor."

### Crack houses on the decline...

The St. Louis epidemiologic source notes a decline in crack houses, possibly because cell phones and beepers are increasingly used and because users know which blocks to drive down in order to make their "connections." The Denver epidemiologic source also reports a long-term decline in crack houses.

### Small-group versus private use...

The Baltimore ethnographic source explains that "crack users tend to smoke their drug alone, not in groups, because of the short duration of the high." A Honolulu treatment source points out, however, that group use is more economical: friends can share costs and, when availability is low, they can share the drug.

non-methadone programs), public use is more common than private use in only one (the Columbia non-methadone program), and solo use is more common than social use in only six programs (at the methadone programs Chicago, Detroit, New Orleans, and Washington, DC, and at the non-methadone programs in the Miami and Washington, DC). A treatment source in Honolulu points out that people tend to use crack in small groups and among friends in order to share costs and, when availability is low, to share the drug.

## POWDER COCAINE: THE PERCEPTION

### How do *Pulse Check* sources perceive the powder cocaine problem in their communities?

Boston is the only community in which a *Pulse Check* source (the law enforcement source) names powder cocaine as the most widely abused drug. In Denver, one source (from non-methadone treatment) considers both crack and powder cocaine as that city's most widely abused drugs, and the other three *Pulse Check* sources consider powder cocaine as the second most widely abused drug (following marijuana). It is also considered the second most widely abused drug by sources in El Paso, New Orleans, and New York.

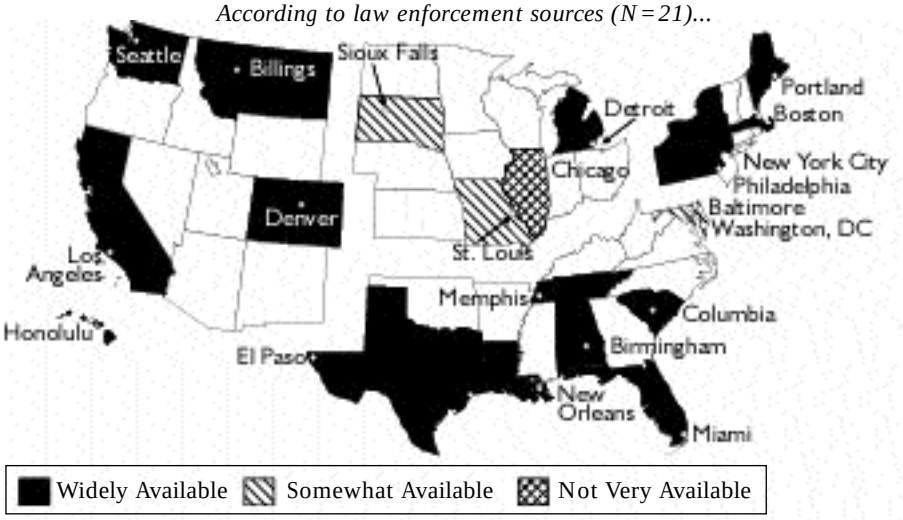
Also in Denver, two sources (law enforcement and epidemiologic) name powder cocaine as the drug with the most serious consequences, whether medically, legally, societally, or otherwise. In Memphis, too, one source (non-methadone treatment) puts powder cocaine into that category.

### Has the perception of the powder cocaine problem changed between fall 2000 and spring 2001?

Two sources who named powder cocaine as their communities' most widely abused drug during the last *Pulse Check* reporting period perceive a change: the Memphis non-methadone treatment source believes that crack has replaced powder cocaine, and the Portland (ME) law enforcement source believes that heroin and diverted pharmaceutical opiates have replaced it. The Portland law enforcement source also believes that diverted pharmaceutical opiates have replaced powder cocaine as the drug with the most serious consequences. By contrast, in Memphis, the non-methadone source perceives that powder cocaine has replaced crack in causing the most serious consequences. No sources in any other *Pulse Check* cities believe powder cocaine to be associated with any new or emerging problems.

**Exhibit 1.**
**How available is powder cocaine across the 21 *Pulse Check* cities?**

*According to law enforcement sources (N=21)...*




*According to epidemiologists and ethnographers (N=21)...**


**The epidemiologic source in Columbia did not provide this information.*

## POWDER COCAINE: THE DRUG

### How available is powder cocaine across the country? *(Exhibit 1)*

Powder cocaine is considered widely available in 18 of the 21 *Pulse Check* cities (the 3 exceptions are St. Louis, Sioux Falls, and Washington, DC), according to nearly two-thirds (27 of 41) of law enforcement, epidemiologic, and ethnographic sources who discussed this question. Ten sources in eight cities describe it as "somewhat available": Boston and Philadelphia in the Northeast; Baltimore and Washington, DC, in the South; St. Louis and Sioux Falls in the Midwest; and Honolulu and Seattle in the West. Only four sources consider the drug not very available: two in the West (Billings and Los Angeles), and two in the Midwest (Chicago and St. Louis).

**Has powder cocaine availability changed?** *(Exhibit 2)* Powder cocaine availability remained stable between fall 2000 and spring 2001, according to the majority (18 of 20) of *Pulse Check* law enforcement sources who discussed this question. Only two of those sources perceive an increase (in Columbia, SC, and in Portland, ME), and no declines are reported. Trends are more mixed, however, according to the 20 epidemiologic and ethnographic sources who discussed this question: powder cocaine availability increased in 5 sites, declined in 5, and remained stable in 10. Regionally, trends are mixed: in the Northeast, stable trends are reported in New York, Philadelphia, and Portland, while a decline is reported in Boston; in the South, supply declined in El Paso, Miami, and Washington, DC, remained stable in Memphis and New Orleans, and increased in Birmingham; in the Midwest, availability increased in Chicago and Detroit and remained stable in Sioux Falls and St. Louis; and in the West, availability increased in Denver and Seattle and remained stable in Billings and Los Angeles.

**Exhibit 2.**
**How has powder cocaine availability changed (fall 2000 vs spring 2001)?***

**Increased**
Birmingham, AL[E]
Chicago, IL[E]
Columbia, SC[L]
Denver, CO[E]
Detroit, MI[E]
Portland, ME[L]
Seattle, WA[E]

**Stable**

| | |
|---|---|
| Baltimore, MD[L,E] | Memphis, TN[E] |
| Billings, MT[L,E] | Miami, FL[L] |
| Birmingham, AL[L] | New Orleans, LA[L,E] |
| Boston, MA[L] | New York, NY[L,E] |
| Chicago, IL[L] | Philadelphia, PA[L,E] |
| Denver, CO[L] | Portland, ME[E] |
| Detroit, MI[L] | Seattle, WA[L] |
| El Paso, TX[L] | Sioux Falls, SD[L,E] |
| Honolulu, HI[L] | St. Louis, MO[L,E] |
| Los Angeles, CA[L,E] | Washington, DC[L] |

**Decreased**
Boston, MA[E]
El Paso, TX[E]
Honolulu, HI[E]
Miami, FL[E]
Washington, DC[E]

[L] *Law enforcement respondents*
[E] *Epidemiologic/ethnographic respondents*
**The Boston and Columbia epidemiologic/ethnographic sources and the Memphis law enforcement source did not respond.*

**What are powder cocaine prices and purity levels across the country?** *(Exhibit 3)* Grams and "eightballs" (1/8 ounce) are the sales units most commonly reported by law enforcement, epidemiologic, and ethnographic sources. Grams range in price from a low of $28 in New York to a high of $150 in New Orleans, with $100 the most frequently reported price. Eightballs sell for as low as $80 in Seattle and as high as $400 in Memphis. Gram-level purity ranges from a low of 20 percent in Denver and Washington, DC, to a high of 90 percent in Detroit and Miami.

**Exhibit 3.**
**How much do grams and "eightballs" of powder cocaine cost in 17 *Pulse Check* cities?***

**GRAM**

| | City | Price | Purity |
|---|---|---|---|
| Northeast | Boston, MA | $60 | 50–60% |
| | New York, NY | $28–$30 | 75% |
| | Philadelphia, PA | $100–$125 | 60–80% |
| | Portland, ME | $80–$100 | 30–70% |
| South | Birmingham, AL | $100 | NR |
| | Columbia, SC | $100 | NR |
| | Memphis, TN | $100 | 40–50% |
| | Miami, FL | $40–$60 | 80–90% |
| | New Orleans, LA | $25–$150 | NR |
| | Washington, DC | $100 | 20–60% |
| Midwest | Chicago, IL | $125 | NR |
| | Detroit, MI | $70–$125 | 60–90% |
| | Sioux Falls, SD | $80–$100 | NR |
| West | Denver, CO | $100 | 20–50% |
| | Honolulu, HI | $100–$120 | NR |
| | Los Angeles, CA | $80 | 80–85% |
| | Seattle, WA | $80–$100 | 57–58% |

**"EIGHTBALLS" (1/8 OUNCE)**

| | City | Price | Purity |
|---|---|---|---|
| Northeast | Boston, MA | $200–$250 | 60% |
| | Portland, ME | $250 | 50% |
| South | Columbia, SC | $250–$300 | NR |
| | Memphis, TN | $350–$400 | 40–50% |
| Midwest | Sioux Falls, SD | $275 | NR |
| West | Seattle, WA | $80–$100 | NR |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
**Respondents in Baltimore, Billings, El Paso, and St. Louis did not provide this information.*

**How much powder cocaine can $10 buy?** In several cities, law enforcement, epidemiologic, and ethnographic sources report units of sale, often called "dime bags," that sell for $10 apiece:

- "A little cellophane bag" in Baltimore
- 0.1–0.2 grams in Denver
- 0.1 gram in Detroit
- 0.5 gram in New Orleans
- 0.25 gram in Seattle
- 150–150 milligrams in Washington, DC

**Then and Now: Powder cocaine prices and purity, fall 2000 vs spring 2001**

*Powder cocaine prices and purity levels remained relatively stable since the last* Pulse Check *reporting period, according to law enforcement sources, with only two exceptions: the Los Angeles source notes an increase in the gram price (from $70 to $80) attributable to market fluctuation, while the El Paso source notes a drop in the price of a "hit" (weight unknown), from $10 to $3. The El Paso epidemiologic source confirms a price drop, noting that powder cocaine, like heroin, is now cheaper and more abundant on the American side of the border than on the Mexican side. Again, these changes are apparently the result of competition for the market by the same three different cartels involved in the heroin trade. Similarly, in the Northeast, the New York ethnographic source notes that high availability and purity levels are allowing dealers to sell three separate qualities: pure (the most expensive); semi-pure (medium priced); and compressed (the least expensive). Also, because powder cocaine is so plentiful and cheap in New York, some crack users are buying powder cocaine to snort it, freebase it, or mix their own crack.*

What adulterants are added to powder cocaine? In addition to baking soda, which is a standard ingredient added to powder cocaine to make crack, *Pulse Check* law enforcement, epidemiologic, and ethnographic sources cite several adulterants, including crystalline stereoisomeric cyclic alcohols (such as inositol and mannitol) in Columbia (SC), El Paso, Honolulu, and Miami. Other adulterants mentioned include lactose in Boston, "any powder" in Miami and Portland (ME), and baby laxatives, vitamin B, and vitamin C in Memphis. The Detroit law enforcement source reports that powder cocaine might be mixed with other drugs, such as heroin.

How is powder cocaine referred to across the country? *(Exhibit 4)* As in the case of crack, users in the South refer to powder cocaine with a wider variety of slang names than users in the other three regions. Crack and powder cocaine names are not interchangeable in most cities.

How is powder cocaine packaged and marketed? Powder cocaine is generally packaged in plastic bags of some sort—whether cellophane, glassine, coin, zipper type, heat sealed, or even just the torn-off corner of a sandwich bag (as is the case in Columbia, SC)—according to law enforcement, epidemiologic, and ethnographic sources in all but one *Pulse Check* city. Los Angeles is the exception: that city's law enforcement source reports that the drug is sold only in "bindles." Bindles—foldover, stapled, knotted, or taped packages made of plain paper, cellophane, glassine, magazine paper, dollar bills, or lottery tickets—are reported in several other cities as well: New York in the Northeast; Baltimore, El Paso, and Memphis (where folded pieces of paper are called "pony packs") in the South; Chicago, Detroit, and St. Louis in the Midwest; and Honolulu, Los Angeles (as mentioned above), and Seattle in the West. Other methods of packaging include tin or aluminum foil (in Detroit, New York, and Washington, DC), compressed bricks (in Billings and New York), balloons (in Denver and El Paso), vials (in Baltimore, Philadelphia, and Seattle), and glue tubes (in Denver). In Billings, the law enforcement source reports that plastic bags containing powder cocaine are sometimes inserted into perfume containers or motor oil cans.

"Retro" packaging for powder cocaine: Back to the Seventies?

One dealer in New York informed the *Pulse Check* ethnographic source, "I'm packaging coke in sexy magazine paper, like *Playboy*, like in the Seventies." He also stated that "coke keeps better in the magazine paper than in plastic or aluminum."

**Exhibit 4.**
**How is powder cocaine referred to across different regions of the country?**


*Sources: Law enforcement, treatment, epidemiologic, and ethnographic respondents*

In some cities, dealers add logos, insignias, or pictures to the packaging. Such is the case in three southern cities: Memphis (logos on baggies sold in head shops), Miami (brand name insignia), and New Orleans (pictures of horses, cats, and stars on bags). Logos in New Orleans reportedly change often. In Chicago, kilo packages sometimes have cartoon characters stamped on the wrappers, and sometimes the inner and outer wrappers have different cartoon stamps. In Denver, too, wrappers have various logos, such as scorpions and stars.

## POWDER COCAINE: THE SELLERS

Then and Now:

How have powder cocaine sellers and sales changed across the country (fall 2000 vs spring 2001)?

*Only one notable change is noted since the previous* Pulse Check *reporting period: in New York, powder cocaine dealers have added ecstasy to the many other drugs they sell. Elsewhere, the powder cocaine sales market has remained generally stable.*

**How are powder cocaine sellers organized?** In only three cities do law enforcement sources report that powder cocaine sales operate predominantly within an organized structure, such as a gang: Birmingham in the South, and Billings and Seattle in the West. Both independent and organized sales structures are reported in Chicago, El Paso, New Orleans, Los Angeles, and Portland, ME (loose networks, not ganglike). In every other *Pulse Check* city, law enforcement sources report that powder cocaine dealers operate independently. By contrast, as in the case of heroin and crack, epidemiologic and ethnographic sources generally categorize powder cocaine dealers as affiliated with some sort of organized structure. Independent dealers are mentioned only in Boston, Birmingham, Memphis, and Denver. In Boston, where both types of operations are reported, those who are organized tend to be Dominican people who are part of a larger distribution network.

**How old are street-level powder cocaine sellers?** All but four law enforcement sources name young adults (18–30 years) as the predominant sellers of powder cocaine. In El Paso and Portland (ME), young adults and adults older than 30 are equally likely to sell the drug. In Los Angeles, both young adults and adolescents are named as the primary sellers. And in Philadelphia, older adults predominate. Epidemiologic and ethnographic sources are even more in agreement that young adults are the predominant sellers of powder cocaine. Only two report otherwise. In Boston, both young and older adults are likely to sell the drug. And, in Chicago, disturbingly, the primary sellers are reportedly adolescents.

**What other drugs do powder cocaine dealers sell?** *(Exhibit 5)* New York is the only *Pulse Check* site in the Northeast where law enforcement, epidemiologic, and ethnographic sources report polydrug sales by powder cocaine dealers—sometimes as many as four additional drugs (marijuana, crack cocaine, heroin, and ecstasy). In the West, by contrast, polydrug sales are reported

**Exhibit 5.**
**What other drugs do powder cocaine dealers sell?***

| | | Marijuana | | Heroin | | Crack Cocaine | | Methamphetamine | | Ecstasy | | No Other Drugs Sold | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | City | LE | E | LE | E | LE | E | LE | E | LE | E | LE | E |
| Northeast | Boston, MA | | | | | | | | | | | ✓ | ✓ |
| | New York, NY | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | | |
| | Philadelphia, PA | | | | | | | | | | | ✓ | |
| | Portland, ME | | | | | | | | | | | ✓ | |
| South | Baltimore, MD | | | ✓ | ✓ | | | | | | | | |
| | Birmingham, AL | ✓ | ✓ | | | ✓ | | | | | ✓ | | |
| | Columbia, SC | ✓ | | | | | | | | | | | |
| | El Paso, TX | | | | | | | | | | | ✓ | |
| | Memphis, TN | | | | ✓ | | ✓ | | | | | ✓ | |
| | Miami, FL | ✓ | | | ✓ | ✓ | | | | | | | |
| | New Orleans, LA | ✓ | | | | ✓ | | | | ✓ | | | ✓ |
| | Washington, DC | | | | | | | | | | | ✓ | |
| Midwest | Chicago, IL | | | | ✓ | | ✓ | | | | | ✓ | |
| | Detroit, MI | | ✓ | | | | | | | | | ✓ | |
| | St. Louis, MO | ✓ | | | | | | | | | | | |
| | Sioux Falls, SD | ✓ | | | | | | ✓ | | | | | ✓ |
| West | Billings, MT | | | | | ✓ | | ✓ | | | | | |
| | Denver, CO | | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | | |
| | Honolulu, HI | ✓ | | | | | | ✓ | | | | | |
| | Los Angeles, CA | | | | | | | | | ✓ | | | |
| | Seattle, WA | ✓ | | ✓ | | | | | | | | | |

*Sources: Law enforcement (LE) and epidemiologic and ethnographic (E) respondents*
**Epidemiologic and ethnographic sources in Billings, Columbia, El Paso, Honolulu, Los Angeles, Philadelphia, Portland, St. Louis, Seattle, and Washington, DC, did not provide this information.*

in every site. Sources in the South and Midwest, however, paint a mixed picture, with dealers in some cities engaged in multiple drug sales and dealers in other cities selling only powder cocaine. Overall, marijuana is reported in 11 cities, followed by crack and heroin (in 7 cities each). Methamphetamine is mentioned in only four cities (three in the West), as is ecstasy. Additionally, the Detroit epidemiologic source reports that some powder cocaine dealers also sell LSD. The only change in this aspect of the sales scene is reported in New York, where ecstasy sales by powder cocaine dealers are a new phenomenon.

Do powder cocaine sellers use their own drug? Law enforcement sources in Billings, Boston, Sioux Falls, and Washington, DC, believe that powder cocaine sellers are very likely to use their own drug. In nearly every other *Pulse Check* city, they describe these sellers as "somewhat likely" to use it. Only in Denver and Miami do law enforcement sources believe that powder cocaine dealers are not very likely to use their drug.

Epidemiologic and ethnographic sources in four cities, all in the South (Baltimore, Birmingham, El Paso, and Memphis), believe that powder cocaine sellers are very likely to use their own drug. Independent dealers in Boston are also very likely to use their own powder cocaine, but dealers affiliated with an organization in that city are not likely to do so at all. The Detroit source considers sellers somewhat likely to use their own drug. The remaining sources who discussed this topic believe that this practice is not very likely.

What type of crimes are powder cocaine sellers involved in? All but three *Pulse Check* law enforcement sources believe that cocaine sellers are very likely or somewhat likely to be involved in crime. The exceptions are in Columbia (SC), St. Louis, and Washington, DC, where dealer involvement in crime is considered not very likely. The majority of the responding sources (14 out of 20) name nonviolent crime, and half (10) name violent crime (less so than for crack). Specifically, gang-related activity is mentioned in nine cities (Boston in the Northeast; Chicago in the Midwest; Baltimore, Birmingham, Memphis, and New Orleans in the South; and Billings, Los Angeles, and Seattle in the West), while prostitution is mentioned in eight (Boston, Philadelphia, and Portland in the Northeast; Birmingham, Memphis, and New Orleans in the South; and Denver and Honolulu in the West). The nonviolent crimes specified include burglaries, auto break-ins, and shoplifting in Columbia; money laundering in Miami; and aiding illegal aliens in El Paso.

Epidemiologic and ethnographic sources in the South express varied opinions on whether powder cocaine sellers are involved in crime. Those in Baltimore, El Paso, and Miami believe that very likely to be the case, while those in Memphis and New Orleans consider it somewhat likely, and those in Birmingham and Washington, DC, consider it not very likely. The most commonly named activities are violent crime and gang-related crimes (in Detroit and in four southern cities), nonviolent crime (in Honolulu and four southern cities), and prostitution (in Boston and in three southern cities). Domestic violence is mentioned in El Paso, and drug rape is mentioned in Miami.

Where is powder cocaine sold? *(Exhibit 6)* In many *Pulse Check* cities, street-level powder cocaine sales, like heroin and crack sales, take place in central city areas, as reported in the last *Pulse Check*. However, as also reported in the last *Pulse Check*, suburban areas are frequently mentioned as well, more so than for heroin or crack. Specifically, both suburban and central city locations are named by law enforcement sources in seven sites: Miami and New Orleans in the South; Detroit and Sioux Falls in the Midwest; and Denver, Los Angeles, and Seattle in the West. Furthermore, areawide sales (spanning central city, suburban, and rural areas) are reported in the Northeast (Boston, New York, and Portland) and the South (Birmingham and Memphis). In El Paso, the suburbs, exclusively, are named as the likeliest location for powder cocaine sales.

According to epidemiologic and ethnographic sources who discussed this question, central city areas are the predominant sales locations in Baltimore, Memphis, New Orleans, New York, and Washington, DC. Suburban areas are named in Detroit, Miami, and Sioux Falls. Both types of areas are named in Boston, Chicago, Birmingham, and El Paso. In Denver, sales occur in all three types of city locations (including rural areas).

Powder cocaine is sold both indoors and outdoors, according to the majority (14 of 21) of law enforcement sources. However, indoor sales locations are more frequent in Chicago, Detroit, Portland (ME), and Seattle,

**Exhibit 6. Where is street-level powder cocaine sold and used?***

| | City | Street | | Private Residences | | Clubs | | Public Housing | | College | | Crack Houses | | Schools | | Parties | | Shopping Malls | | Inside Cars | | Parks | | Raves | | Supermarkets | | # of Settings | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use |
| *Northeast* | Boston, MA | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | | ✓ | | ✓ | | 12 | 1 |
| | New York, NY | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | 13 | 10 |
| | Philadelphia, PA | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | ✓ | ✓ | | | | | | ✓ | ✓ | | | | | | | 5 | 3 |
| | Portland, ME | ✓ | | ✓ | ✓ | | ✓ | | ✓ | | | | | | | | ✓ | | | ✓ | | | | | | | | 3 | 4 |
| *South* | Baltimore, MD | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | 11 | 11 |
| | Birmingham, AL | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | ✓ | ✓ | | 12 | 4 |
| | Columbia, SC | ✓ | | | | | | ✓ | | | | | | | | | | | | | | | | | | ✓ | | 3 | 0 |
| | El Paso, TX | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 13 | 13 |
| | Memphis, TN | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | ✓ | ✓ | | 12 | 7 |
| | Miami, FL | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | 11 | 7 |
| | New Orleans, LA | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | | ✓ | | 11 | 3 |
| | Washington, DC | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | ✓ | | ✓ | | | | ✓ | ✓ | | | ✓ | | | | 9 | 4 |
| *Midwest* | Chicago, IL | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | | ✓ | ✓ | | | ✓ | ✓ | | ✓ | | ✓ | | | 8 | 8 |
| | Detroit, MI | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | ✓ | ✓ | | | ✓ | ✓ | | ✓ | | | | | 5 | 6 |
| | St. Louis, MO | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | | | | 8 | 5 |
| | Sioux Falls, SD | ✓ | | ✓ | | ✓ | | ✓ | ✓ | | | | | | | ✓ | ✓ | | | | | | | | | | | 5 | 2 |
| *West* | Billings, MT | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | | 11 | 2 |
| | Denver, CO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | | | | | 10 | 7 |
| | Honolulu, HI | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | | ✓ | | | | ✓ | | | | ✓ | | ✓ | | 10 | 3 |
| | Los Angeles, CA | | | ✓ | ✓ | ✓ | | | ✓ | | | | | | | ✓ | | | | | | | | | ✓ | | | 3 | 3 |
| | Seattle, WA | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | ✓ | | | ✓ | ✓ | | ✓ | | | | | 5 | 7 |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
**The epidemiologic/ethnographic sources in Billings, Boston, Columbia, Los Angeles, Seattle, and Sioux Falls did not provide seller setting information.*
**The epidemiologic/ethnographic source in Columbia did not provide user setting information. The Boston source for user setting gave an overall response: "most private setting available."*

while outdoor locations are more frequent in Miami, Philadelphia, and Sioux Falls. Epidemiologic and ethnographic sources similarly report both types of locations in Chicago, Baltimore, Denver, El Paso, Memphis, and New Orleans. Indoor locations, however, are more frequent in Birmingham, Detroit, Miami, New York, and Sioux Falls, while outdoor locations are more frequent in Washington, DC.

The specific settings for powder cocaine sales are as varied as those for heroin and crack. Private residences, public housing, and clubs are named as sales sites by law enforcement, epidemiologic, and ethnographic sources in nearly every *Pulse Check* city. Cars and parties are the next most common settings, followed by college campuses, schools, and raves. No rave sales are reported in the Midwest. Crack houses are mentioned in only 10 cities, predominantly in the Northeast and the South. Supermarket areas are also mentioned in 10 cities, but none are in the Midwest.

## POWDER COCAINE: THE USERS

**How old are powder cocaine users?** Young adults (18–30 years) are the predominant powder cocaine users in 10 of 20 *Pulse Check* cities, according to responding epidemiologic and ethnographic sources. People older than 30 are more likely to use the drug in nine cities, mainly in the South (Baltimore, Memphis, Miami, New Orleans, and Washington, DC) as well as in Boston, Chicago, Denver, and Seattle. In Detroit, both younger and older adults are equally likely to use the drug.

Findings are even more dramatic in non-methadone treatment programs: young adults are the age group likeliest to use powder cocaine in nearly every *Pulse Check* city. There are only five exceptions. Young adults and older adults alike are the predominant users in Philadelphia. Older adults are more predominant in Denver. Young adults and adolescents are equally predominant in Los Angeles. And adolescents are actually the most likely to use powder cocaine in Columbia (SC) and one of the Sioux Falls programs.

**Then and Now:**

**How have powder cocaine users changed across the country (fall 2000 vs spring 2001)?**

***According to epidemiologic and ethnographic sources....***

| | |
|---|---|
| *In five* Pulse Check *cities, more younger people—sometimes adolescents—are reportedly using powder cocaine:* | ➤ **Birmingham, AL:** Young adults are the most likely to use powder cocaine, but the drug is becoming trendier among adolescents, who are moving away from crack.<br>➤ **Detroit, MI:** Young adults (18–30 years) have been increasingly using powder cocaine, so that they now equal older adults (>30 years) as the groups most likely to use the drug.<br>➤ **Los Angeles, CA:** Young adults are the most likely to use powder cocaine, reflecting a slight resurgence in use among "business person types."<br>➤ **Sioux Falls, SD:** Young adults are the most likely to use powder cocaine, but an increase is reported among adolescents, particularly females.<br>➤ **Washington, DC:** While older adults (>30 years) remain most likely to use powder cocaine, the younger adult (18–30 years) group is increasing. |
| *A few reported shifts reflect a spread to the suburbs and to different racial/ethnic and socioeconomic groups:* | ➤ **Portland, ME:** Anecdotal data suggest that powder cocaine use might be spreading from the central city into the suburbs.<br>➤ **Washington, DC:** While Blacks remain the racial/ethnic group most likely to use powder cocaine, Whites have been increasingly using the drug. Likewise, powder cocaine users are predominantly lower SES central city residents, but use is reportedly increasing among middle SES suburbanites. |
| *Shifting use patterns are reported in four cities:* | ➤ **Columbia, SC:** A slight shift to injection is noted, but snorting still predominates.<br>➤ **Los Angeles, CA:** Some resurgence of injection (with no other drugs) is reported, but snorting still predominates. Also, a new combination is reported: powder cocaine plus ecstasy.<br>➤ **Portland, ME:** Smoking is increasing, but snorting still predominates.<br>➤ **Washington, DC:** While powder cocaine is usually injected (in speedballs), snorting has been increasing, particularly in nightclubs, bars, and private parties. Such locations are emerging settings for powder cocaine use. However, the predominant settings remain crack houses, private residences, public housing developments, and cars. |
| ***According to treatment sources...***<br>*The number of novice users of powder cocaine (any drug treatment client who has recently begun using the drug) has increased among clients in several programs in five cities:* | ➤ **Chicago, IL** (methadone)<br>➤ **Columbia, SC** (methadone and non-methadone)<br>➤ **El Paso, TX** (methadone and non-methadone)<br>➤ **Memphis, TN** (non-methadone)<br>➤ **New York, NY** (non-methadone) |
| *Conversely, novice use has declined among clients in non-methadone programs in two cities:* | ➤ **Denver, CO**<br>➤ **Portland, ME** |

Methadone treatment clients who use powder cocaine tend to be older than their counterparts in non-methadone treatment. People older than 30 are named as the predominant user group in seven cities (Boston, Chicago, Detroit, Los Angeles, and Washington, DC), while younger adults are named in five (Boston, Columbia, Denver, El Paso, and New Orleans).

### Are there any gender differences in who uses powder cocaine?

Epidemiologic and ethnographic sources generally agree that males are more likely than females to use powder cocaine. In this respect, powder cocaine users resemble heroin users (who are more likely to be males) rather than crack users (who are equally likely to be males and females in many cities). In three *Pulse Check* cities, however, males and females are equally likely to use the drug: New York, Portland (ME), and Sioux Falls. Furthermore, the gender of powder cocaine users is sometimes related to their age. In Detroit, for example, older (>30 years) powder cocaine users are predominantly males, but the younger adult (18–30 years) user group is evenly split between the genders.

Treatment sources, by contrast, paint a picture that includes more females. Women and men are equally likely to use powder cocaine in nine non-methadone programs (in Chicago, Los Angeles, Seattle, Philadelphia, Washington, DC, and both programs in Billings and Sioux Falls) and six methadone programs (in Boston, Columbia [SC], Chicago, Detroit, Denver, and Seattle). Moreover, in the Los Angeles methadone program, female powder cocaine users outnumber males.

### Is any racial/ethnic group more likely to use powder cocaine?

*(Exhibit 7)* Powder cocaine users, compared with crack users, are more likely to be White, as reported by both epidemiologic and ethnographic sources and non-methadone treatment sources; conversely, they are less likely to be Black than crack users. As reported in the last *Pulse Check*, their racial/ethnic breakdowns are more similar to those of heroin users than to those of crack users.

Regionally, according to epidemiologic and ethnographic sources, the South is the only region with a mix of racial/ethnic groups as the predominant powder cocaine users: Blacks are named in four cities, Whites in three, and Hispanics in one (Miami). The other three regions seem to have predominantly White users in every city except Chicago, where Blacks are the predominant group. Non-methadone treatment sources give slightly different regional breakdowns: Black users seem to be more concentrated in the Midwest than in the other regions, while Whites generally tend to be the predominant user group elsewhere. Hispanics, however, are considered the likeliest racial/ethnic group to use powder cocaine in El Paso and Miami, and they are about equal to Whites and Blacks in Philadelphia and Los Angeles.

**Exhibit 7.**
**What racial/ethnic group is most likely to use specific drugs?***

| | City | Heroin | | Crack | | Powder Cocaine | |
|---|---|---|---|---|---|---|---|
| | | E | N | E | N | E | N |
| Northeast | Boston, MA | White | White | Black | White | White | White |
| | New York, NY | White | White | NR | NR | NR | NR |
| | Philadelphia, PA | White | Black/ Hispanic | Black | All | **White** | All |
| | Portland, ME | White | White | White | White | White | White |
| South | Baltimore, MD | **Black** | Black | Black | Black | **Black** | White |
| | Birmingham, AL | Black/White | **Black** | Black/White | **Black** | Black/White | White |
| | Columbia, SC | **Black**/White | NR | Black | **White** | **Black** | **White** |
| | El Paso, TX | Hispanic | **Hispanic** | Black | All | **White** | Hispanic |
| | Memphis, TN | **White** | NR | **White** | Black | **Black** | Black |
| | Miami, FL | **White** | Hispanic | **Black** | **Black** | Hispanic | Hispanic |
| | New Orleans, LA | **Black** | Black | **Black** | Black | White | NR |
| | Washington, DC | **Black** | Black | **Black** | Black | **Black** | **Black** |
| Midwest | Chicago, IL | **Black** | **Black** | **Black** | Black | **Black** | **Black** |
| | Detroit, MI | White | **Black** | White | **Black** | White | Black |
| | St. Louis, MO | Black | **Black** | **Black** | **Black** | **White** | Black/White |
| | Sioux Falls, SD | White | NR | White | Black | White | Black/White |
| West | Billings, MT | White | White | White | White/ American Indian | White | White |
| | Denver, CO | White | White | White | **Black** | White | **Black** |
| | Honolulu, HI | **White** | **White** | **White** | NR | **White** | White |
| | Los Angeles, CA | Hispanic | Hispanic | **Black** | All | White | All |
| | Seattle, WA | White | NR | **Black** | White/ Hispanic | **White** | White |

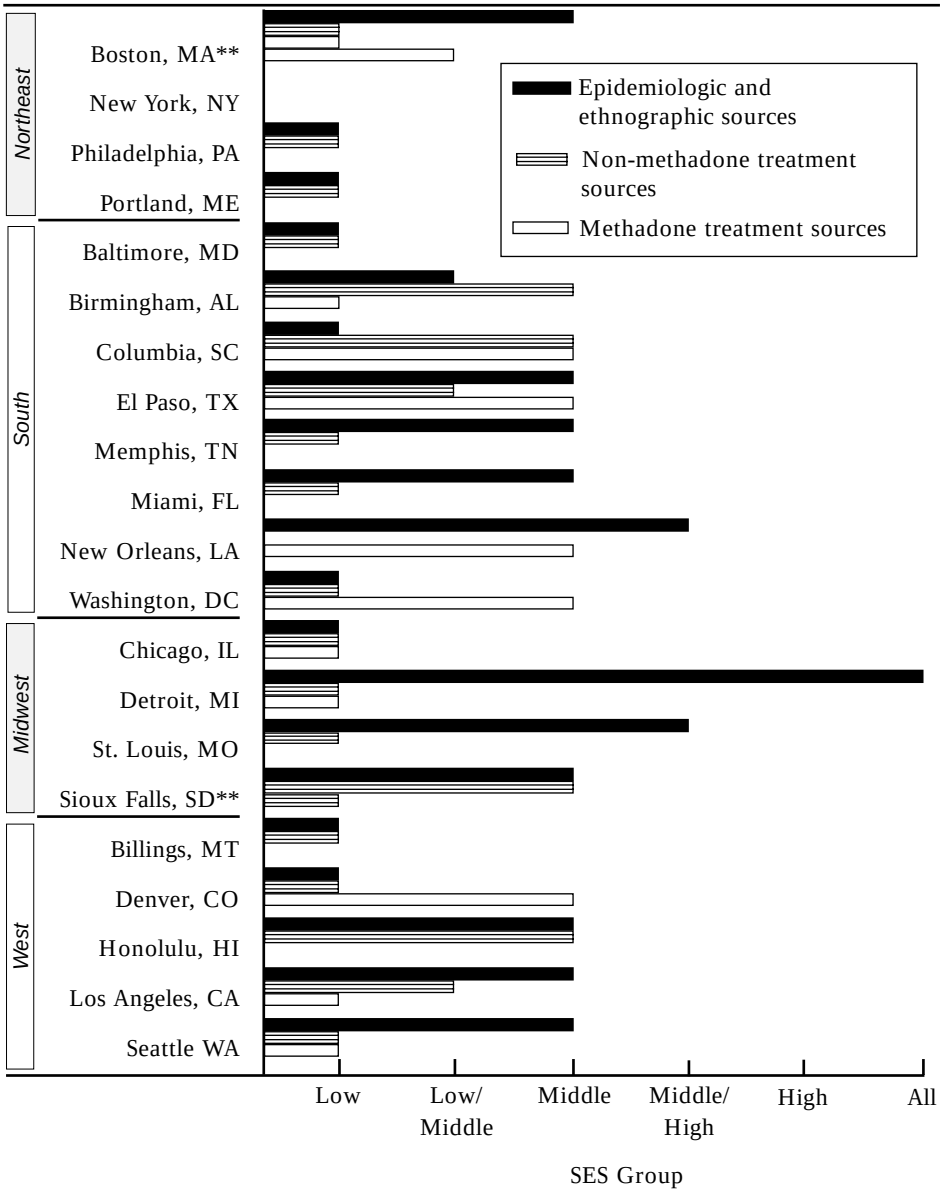
*Sources: Epidemiologic/ethnographic (E) and non-methadone treatment (N) respondents*
**Shaded boxes indicate that a given drug-using population is overrepresented relative to that city's general population. Not all sources, however, had this information available.*

What is the most common socioeconomic background of powder cocaine users? *(Exhibit 8)* Low and middle SES backgrounds are reported approximately equally by epidemiologic and ethnographic sources in their descriptions of powder cocaine users–unlike their descriptions of heroin and crack users, which tend to be more on the "low" side. The only exceptions are in New Orleans and St. Louis, where sources describe powder cocaine users as "middle to high" SES, and in Detroit, where users come from all backgrounds. No regional patterns are evident. Similarly, methadone treatment sources are split about evenly in the two responses. Non-methadone treatment sources, by contrast, tend to name low SES groups more frequently (15 of 22 respondents).

Where do powder cocaine users tend to reside? Suburban areas are named as the predominant place of residence for powder cocaine users by five epidemiologic and ethnographic sources (in Boston, Los Angeles, Miami, St. Louis, and Sioux Falls). Additionally, users are equally likely to reside in either the central city or the suburbs in New Orleans and Seattle; they reside predominantly in rural areas in El Paso; and all three types of areas are named in Detroit. The remaining 12 epidemiologic and ethnographic sources, however, believe that powder cocaine users reside, for the most part, in central city areas. In Baltimore, the ethnographic source points out that while most powder cocaine users reside in the central city, some suburban residents purchase their drug in the central city "because the suburbs have no open air markets." Similarly, in Portland, ME, users continue to reside predominantly in the central city, but anecdotal data suggest that use might be spreading to the suburbs.

Similarly, powder cocaine users in treatment generally tend to live in central city areas, but many also live in the suburbs, particularly in the South. Among 21 responding non-methadone treatment sources, 10 name central city areas as the likeliest place of residence, 7 name the suburbs (in Birmingham, Columbia, El Paso, and Memphis in the South, and

**Exhibit 8.**
**What is the predominant socioeconomic status of powder cocaine users?***




**This information was not provided by the ethnographic source in New York, the non-methadone treatment sources in New York and one of the Billings programs, and by the methadone treatment sources in Honolulu, Miami, New York, Philadelphia, Portland, and St. Louis.*
***Information was provided from two methadone programs in Boston and two non-methadone programs in Sioux Falls.*

Honolulu and Seattle in the West), 2 name rural areas (in both Sioux Falls programs), and 2 name all locations throughout the area (in Billings and St. Louis). According to responding methadone treatment sources, central city places of residence are more common in Boston, Birmingham, Chicago, Detroit, El Paso, Los Angeles, and Washington, DC, while the suburbs are more common in the second Boston program and in Columbia (SC), Denver, and New Orleans. In Los Angeles and Seattle, non-methadone clients who use powder cocaine are equally likely to live in central city and suburban areas.

**How do powder cocaine users take their drug?** Snorting is the primary route of administration for powder cocaine, according to the vast majority of epidemiologic and ethnographic sources, with a few notable exceptions: injecting (as part of a speedball) is cited as more common in Philadelphia and Washington, DC, and smoking is as common as snorting in Honolulu. In some cities, route of administration varies with age. For example, in Detroit, young adult (18–30 years) powder cocaine users tend to snort the drug, while the older (>30 years) user group is equally likely to snort and smoke it. Epidemiologic and ethnographic sources report three changes in cities where snorting still predominates: a shift towards smoking in Portland (ME), some resurgence of injection in Los Angeles (with no other drugs), and a slight shift to injection in Columbia (SC). Conversely, in Washington, DC, where injection predominates, snorting has been increasing.

**What motivates different age groups to choose snorting over injecting?**

In Baltimore, where speedballing is common, the ethnographic source explains that "street-knowledgeable folks tell how inserting a needle in the skin produces abscesses, so they are more likely to snort, especially with the increased potency. For newcomers, fear of HIV is a deterrent to needle use."

Non-methadone treatment sources concur that snorting is generally the primary route of administration for powder cocaine, but, again, some exceptions are noteworthy. Smoking is the primary route at the programs in Denver and Honolulu. Smoking equals snorting as the primary route in Baltimore and Los Angeles. And injecting equals snorting as the primary route in Billings. Not surprisingly, injecting is mentioned as a primary route of administration by powder cocaine users in some methadone programs, as in Boston, Los Angeles, and Seattle. Moreover, the El Paso methadone treatment source reports that powder cocaine users are likely to either smoke or inject the drug.

**What other drugs do powder cocaine users take?** Epidemiologic and ethnographic sources report that powder cocaine users also consume a variety of other drugs, sometimes in combination, and sometimes sequentially. For example, powder cocaine is often taken as part of a "speedball" combination with heroin, as reported in New York, Philadelphia, and Portland in the Northeast; Memphis in the South; Chicago and Sioux Falls in the Midwest; and Denver and Seattle in the West. In Portland, diverted OxyContin® is sometimes used instead of heroin in this type of speedball. Marijuana is frequently smoked by powder cocaine users in many cities (sometimes sequentially, sometimes laced together), as reported in Boston, Columbia (SC), Detroit, Philadelphia, St. Louis, and Sioux Falls. Diverted benzodiazepines are mentioned by sources in Boston, El Paso (alprazolam, or Xanax®), and St. Louis (diazepam). As part of the club drug scene, powder cocaine is sometimes combined with ecstasy in El Paso; with ecstasy and a whole gamut of club drugs in Miami; and with ecstasy, GHB, or both in Birmingham.

Non-methadone treatment sources in Baltimore, Birmingham, Chicago, Denver, and Philadelphia similarly report that powder cocaine is sometimes combined with heroin. Marijuana is cited by non-methadone treatment sources in Columbia (SC), Denver, Detroit, Los Angeles, Memphis, and Sioux Falls (where the source specifies that it is laced in with the powder cocaine). The combination of powder cocaine and ecstasy is mentioned in four programs: in Billings; in Birmingham, where this phenomenon first appeared around a year ago; in Columbia, where the drugs are specified as a club drug combination; and in Portland, ME, where the use of this combination has increased. Finally, powder cocaine is sometimes combined with methamphetamine in the West, as reported by non-methadone treatment sources in Billings and Honolulu.

Nearly every methadone treatment source, again not surprisingly, reports that powder cocaine is sometimes combined with heroin. Additionally, diverted benzodiazepines are sometimes taken either together with powder cocaine or afterwards to mitigate the side effects, as noted at

programs in Boston, Columbia (SC), and Seattle. The El Paso methadone treatment source adds that some clients also use "roche" (pronounced ro-cha), presumably the benzodiazepine flunitrazepam (Rohypnol), brought in from Mexico.

Where and with whom is powder cocaine used? *(Exhibit 6)* Powder cocaine is usually used indoors, in private, and in small groups among friends. Indoor use is cited by every epidemiologic and ethnographic source except in Washington, DC, where both indoor and outdoor use are equally common. The Baltimore ethnographic source notes seasonal increases in outdoor use as the weather improves, as is the case with heroin use. Private, as opposed to public, use is cited by all the sources but three: in Birmingham, El Paso, and Washington, DC, powder cocaine is used both in public and in private. Only three sources—in New York, Miami, and Los Angeles—report that the drug is used while alone, rather than in small groups among friends. Similarly, among non-methadone treatment sources, only rare reports are given for outdoor use (only in Honolulu, Los Angeles, and Boston), public use (only in Honolulu and Seattle, although both private and public use are reported in Billings, Los Angeles, Memphis, and Washington, DC), or solo use (only in Boston, although both solo and group use is reported in Memphis and Philadelphia).

Private residences, by far, are the most common settings for powder cocaine use, according to epidemiologic and ethnographic sources (as shown previously, in exhibit 6) as well as non-methadone treatment sources. The other most common settings are clubs, parties, and cars. A few unusual use settings are noted by epidemiologic and ethnographic sources. For example, in Portland, ME, powder cocaine is sometimes used on boats (during long fishing trips) and in the woods. In Miami, it is used in restaurant kitchens. And in Baltimore, like heroin and crack, powder cocaine is sometimes used in abandoned row houses (abandominiums) and fast-food restaurant bathrooms.

Overall, any specific setting is usually more likely to be a sales site than a use site for powder cocaine, according to law enforcement, epidemiologic, and ethnographic sources. Schools are a particular case in point: in 11 cities, they are reported as a place where dealers sell powder cocaine but not as a place where users take it. Only in Baltimore and El Paso are schools mentioned as settings for both sales and use. Similarly, public housing developments and the areas around supermarkets are named much more frequently as places where sales, rather than use, occur. In a few cases, however, the opposite holds true. For example, in Portland, ME, three settings named as use sites (clubs, public housing, and parties) are not mentioned as sales sites. Similarly, in Chicago, Detroit, and Los Angeles, powder cocaine is used but not sold in parks.

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## MARIJUANA: THE PERCEPTION

**How do *Pulse Check* sources perceive the marijuana problem in their communities?** Baltimore and Washington, DC, are the only two cities where no *Pulse Check* source names marijuana as their community's most widely abused drug. In the other 19 *Pulse Check* cities, 30 law enforcement, epidemiologic, ethnographic, and non-methadone treatment sources indeed name marijuana as such. Interestingly, Washington, DC, is the only city where a source (law enforcement) considers marijuana to be the drug with the most serious consequences. However, an additional 10 sources in 9 cities (Billings, Birmingham, Denver, Detroit, Los Angeles, Miami, Seattle, St. Louis, and Sioux Falls) name marijuana as the drug related to the second most serious consequences.

**Has the perception of the marijuana problem changed between fall 2000 and spring 2001?** No sources report any change in their perception of marijuana as a widely abused drug or as a drug related to serious consequences in their communities. Three sources, however, perceive that marijuana has been replaced by another drug contributing to the second most serious consequences in their communities: the Birmingham law enforcement source believes that the diversion and abuse of prescription drugs have replaced marijuana, the Columbia (SC) non-methadone treatment source believes that LSD has done so, and the Sioux Falls epidemiologic source believes that club drugs have done so.

**Exhibit 1.**
**How available is marijuana across the 21 *Pulse Check* cities?***

*According to law enforcement, epidemiologic, and ethnographic sources...*


**The Columbia (SC) epidemiologic source did not provide this information.*

## MARIJUANA: THE DRUG

**How available is marijuana across the country and what type of marijuana is available?** *(Exhibits 1 and 2)* Similar to reports in the last *Pulse Check*, nearly all (39 of 41) epidemiologic, ethnographic, and law enforcement sources who discussed this question consider marijuana to be widely available in their communities. The two exceptions are in Boston and Chicago, where one source in each city describes the drug as somewhat available.

The types of marijuana, compared with marijuana in general, vary more in availability as perceived by the *Pulse Check* sources knowledgeable on the subject. The most common variety is locally produced commercial-grade marijuana, ranked as widely available by 24 law enforcement, epidemiologic, and ethnographic sources in all but 3 of the 21 *Pulse Check* cities: Birmingham, Detroit, and St. Louis. Six sources describe local commercial-grade marijuana as somewhat available, three describe it as not very available, and two (in El Paso and Washington, DC) consider it not available at all.

Sinsemilla, or the seedless variety of marijuana, is the second most common variety reported in *Pulse Check* cities, cited as widely available by 13 law enforcement, epidemiologic, and ethnographic sources in 10 cities spanning all regions of the country: Boston, New York, and Portland (ME) in the Northeast; El Paso and Miami in the South; Detroit and St. Louis in the Midwest; and Billings, Honolulu, and Seattle in the West. Another 13 sources in 10 cities describe sinsemilla as somewhat available, 8 sources in 7 cities report it as not very available, and only 1 source (in El Paso) says it is not available at all.

**Exhibit 2.**
**What varieties of marijuana are described as "widely" or "somewhat" available across the 21 *Pulse Check* cities? How has availability changed (fall 2000 vs spring 2001)?***

| | City | Local Commercial | | Sinsemilla | | Mexican Commercial | | Hydroponic | | BC Bud | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | L | E | L | E | L | E | L | E | L | E |
| Northeast | Boston, MA | ●↔ | ● | ●↔ | ❍ | ❍↔ | ● | ●↔ | | | |
| | New York, NY | ●↔ | ●↑ | ●↔ | ●↔ | ●↔ | | ●↔ | ❍↔ | ●↔ | |
| | Philadelphia, PA | ●↔ | ❍↔ | ❍↔ | ❍↔ | | | ●↔ | ❍↔ | ●↔ | |
| | Portland, ME | ●↔ | ●↔ | ●↔ | ●↔ | ❍↔ | ❍ | ●↔ | ❍↔ | ❍↔ | ❍↔ |
| South | Baltimore, MD | ●↑ | ●↔ | ❍↔ | ❍↔ | ❍↔ | ❍↔ | | | | |
| | Birmingham, AL** | | | | | | | | | | |
| | Columbia, SC | ●↔ | | | | ●↔ | | | | ❍ | |
| | El Paso, TX | | ●↔ | | ●↔ | ●↔ | ●↔ | | | | ●↔ |
| | Memphis, TN | ● | ❍ | ❍ | | ● | | ❍ | | | ❍ |
| | Miami, FL | ●↔ | | ●↔ | ●↑ | | | ●↑ | | | |
| | New Orleans, LA | | ●↔ | | ❍↔ | | | ●↔ | ❍↔ | | |
| | Washington, DC | | ●↔ | ❍↔ | | | | ●↑ | ●↔ | | |
| Midwest | Chicago, IL | ❍↔ | ●↔ | ❍↔ | ❍↔ | ❍↔ | ❍↔ | ❍↑ | | | |
| | Detroit, MI | ❍↔ | | ●↔ | ❍↔ | ❍↔ | ●↔ | ❍↔ | ❍ | | |
| | St. Louis, MO | | | ●↔ | | ❍↔ | | | | | |
| | Sioux Falls, SD | ●↑ | | | | | | | | | |
| West | Billings, MT | ●↔ | | ●↔ | | ●↔ | | | | ●↔ | |
| | Denver, CO | ●↔ | ●↑ | | ❍↔ | ●↔ | ●↑ | | ❍↔ | | ❍↔ |
| | Honolulu, HI | ●↑ | ●↔ | ●↑ | | ❍↔ | ❍↓ | ❍↔ | ❍↔ | ❍↑ | |
| | Los Angeles, CA | ❍↔ | ●↔ | | | ●↔ | ●↔ | | ❍↔ | | |
| | Seattle, WA | ❍↔ | ●↔ | ❍↔ | ●↔ | ❍↔ | ●↔ | ❍↔ | | ❍↔ | |

*Sources: Law enforcement (L) and epidemiologic/ethnographic (E) respondents*
● *Widely available*
❍ *Somewhat available*
** Arrows indicate up, down, or stable trends. Absence of an arrow indicates that respondent did not provide trend information.*
***While both Birmingham sources noted marijuana as widely available, neither rated the different varieties.*

Mexican commercial-grade marijuana is as available as sinsemilla, with wide availability cited by 13 sources in 10 cities: Boston and New York in the Northeast; Columbia (SC), El Paso, and Memphis in the South; Detroit in the Midwest; and Billings, Denver, Los Angeles, and Seattle in the West. It is described as somewhat available by another 12 sources across all the regions, not very available by 6 sources, and not available by 3 sources (in New York, New Orleans, and Washington, DC).

Hydroponically grown marijuana is considered widely available by eight sources in seven cities, all either in the Northeast or the South: all four law enforcement sources in the Northeast; both sources in Washington, DC; and the law enforcement sources in Miami and New Orleans. Another 13 sources in 11 cities describe hydroponic marijuana as somewhat available, 9 sources in 9 cities rate it as not very available, and 3 law enforcement sources—in Baltimore, Billings, and El Paso—consider it not available at all.

As reported in the last *Pulse Check*, of all the marijuana varieties discussed, British Columbian ("BC bud") is least commonly considered widely available, with only four sources reporting it as such. Two are in the Northeast (New York and Philadelphia), one is in the South (El Paso), and one is in the West (Billings). An additional 7 sources in 6 cities give it a somewhat available rating, 8 sources in 7 cities consider it not very available, and it is not available at all according to 10 sources in 8 cities: Boston in the Northeast; Baltimore, El Paso, Memphis, Miami, New Orleans, and Washington, DC, in the South; and Detroit in the Midwest.

It is important to note that in some cases, the different varieties of marijuana can overlap. In Seattle, for example, the categories of "sinsemilla," "locally grown," and "hydroponic" are synonymous: the most common form available is locally grown hydroponic sinsemilla.

Has marijuana availability changed? *(Exhibit 3)* Marijuana availability remained stable at high levels between fall 2000 and spring 2001, according to the majority of *Pulse Check* sources who discussed this question (18 of 20 law enforcement sources and 16 of 19 epidemiologic and ethnographic sources). The two law enforcement exceptions are in Baltimore and Sioux Falls, where increased availability appears driven by increases in local commercial grades. The three exceptions among epidemiologic and ethnographic sources are increases in Boston, Denver (where both local and Mexican commercial grades have increased in supply), and New York (where an increase in local

commercial-grade marijuana is noted). No sources report declines in overall marijuana availability.

In some sites where overall availability is stable at high levels, some shifts are reported for specific varieties. For example, the Birmingham law enforcement source reports declining availability for three varieties: Mexican commercial, BC bud, and hydroponic marijuana. Conversely, the Honolulu law enforcement source reports increasing availability for three varieties: local commercial grade, sinsemilla, and BC bud. Several sources report increases in hydroponic marijuana availability: the epidemiologic source in St. Louis and the law enforcement sources in Chicago, Miami, and Washington, DC. The St. Louis epidemiologic source also reports periodic rumors, thus far unconfirmed, of the emergence of BC bud. And the Miami epidemiologic source reports that two varieties have increased in supply: sinsemilla and Jamaican.

### How potent is marijuana across the country and how has potency changed? *(Exhibit 4)*

Marijuana potency ranges from 1–5 percent tetrahydrocannabinol (THC) for Mexican commercial-grade marijuana in Detroit to 15–22 percent THC for sinsemilla in Honolulu, according to reporting law enforcement, epidemiologic, and ethnographic sources. Since the last *Pulse Check*, potency levels remained relatively stable in most reporting cities, except in Memphis, where potency for commercial-grade (domestic and Mexican) marijuana increased, and in Portland (ME), where potency of marijuana in general has increased.

**Exhibit 3.**
**How has marijuana availability changed (fall 2000 vs spring 2001)?***


[L] *Law enforcement respondents*
[E] *Epidemiologic/ethnographic respondents*
**The Boston and Columbia (SC) epidemiologic sources and the Memphis law enforcement source did not provide that information.*

### What are street-level marijuana prices across the country and have they changed since the last reporting period? *(Exhibit 4)*

According to law enforcement, epidemiologic, and ethnographic sources, commercial-grade marijuana (Mexican or domestic) ounce prices are generally in the $100–$200 range, except in Memphis, where a $25 price is reported. Sinsemilla tends to be more expensive, as in Denver, where it sells for $300 per ounce, although it costs as little as $80–$100 per ounce in Boston. BC bud is even more expensive, as in Denver, where it sells for $500 per ounce. The highest reported prices, however, are for hydroponic and organic marijuana, which sell for $700–$800 in New York. Joints and bags of either domestic or Mexican commercial-grade marijuana tend to sell for $5–$10. Since the last reporting period, prices have remained relatively stable in reporting *Pulse Check* cities, except in Seattle, where BC bud prices declined since the last reporting period.

#### "Early-in-the-month" bags?

According to the Baltimore ethnographic source, as a new marketing strategy, marijuana is available in individual joints, for $2–$3 each, toward the latter part of the month, when users' income is lower; then, early in the following month, it is sold in $5 and $10 bags.

### How is marijuana referred to across the country? *(Exhibit 5)*

Similar to reports in previous *Pulse Check* issues, "grass," "pot," and "weed" remain common slang terms for marijuana across *Pulse Check* sites. Additionally, as the New York ethnographic source states, "Brand names dominate the scene." Such is also the case in Philadelphia and in some southern cities, such as Memphis and Miami. Some of the more recent names in New York include "texas tea," "purple haze," "arizona," "elo," "hydro," "dro," "pellet," "beef and broccoli" (a combination of hydro and pellet), and "trees." In Philadelphia, some of the latest names include "$ signs," "8 ball," "horse heads," and "marijuana leaf." The Miami epidemiologic source gives further insight into some of the other names: for example, "'kryppy' is short for 'kryptonite'–because it's THAT strong," and "killer" is so named "because it's the worst; it stinks."

**Exhibit 4.**
**How much does marijuana cost in 19 *Pulse Check* cities?***

| | City | Type | Unit | Price | Purity (%THC) |
|---|---|---|---|---|---|
| Northeast | Boston, MA | Sinsemilla | 1 oz | $80–$100 | NR |
| | New York, NY | NR | Bag | $10 | NR |
| | | Hydroponic and organic | 1 oz | $700–$800 | NR |
| | Philadelphia, PA | Local commercial | 1 oz | $150–$200 | NR |
| | Portland, ME | NR | 1 oz | $175 | NR |
| South | Baltimore, MD | NR | Bag | $5–$10 | NR |
| | Birmingham, AL | NR | 1 gm (joint) | $10 | NR |
| | Columbia, SC | Local or Mexican commercial | 3–4 gm | $10 | NR |
| | El Paso, TX | Mexican commercial | 1/4 oz | $20 | NR |
| | Memphis, TN | Local commercial | 1 oz | $25 | 5–6% |
| | | NR | 1/4 oz | $25–$30 | NR |
| | Miami, FL | Sinsemilla | 1/4 oz | $100 | 10–18% |
| | | Sinsemilla | Bag | $750–$1,200 | NR |
| | New Orleans, LA | Domestic commercial | Joint | $5–$10 | NR |
| | Washington, DC | Local or Mexican commercial | 1/4 oz | $25–$75 | NR |
| | | Local or Mexican commercial | 750 mg bag | $20 | NR |
| Midwest | Chicago, IL | Local or Mexican commercial | Bag | $5–$10 | NR |
| | Detroit, MI | Mexican commercial | 1 oz | $150–$200 | 1–5% |
| | Sioux Falls, SD | Local commercial | 1 oz | $100–$150 | NR |
| West | Denver, CO | Local or Mexican commercial | 1 oz | $100–$200 | 4% |
| | | Sinsemilla | 1 oz | $300 | NR |
| | | BC bud | 1 oz | $500 | 4% |
| | Honolulu, HI | Mexican commercial | Joint | $5 | NR |
| | | Kona gold | Joint | $20 | NR |
| | | Sinsemilla | 1 gm | $25 | 15–22% |
| | Los Angeles, CA | Mexican commercial | Joint | $10 | 4–6% |
| | Seattle, WA | BC bud | 1 gm | $15–$25 | NR |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
**Respondents in Billings and St. Louis did not provide this information.*

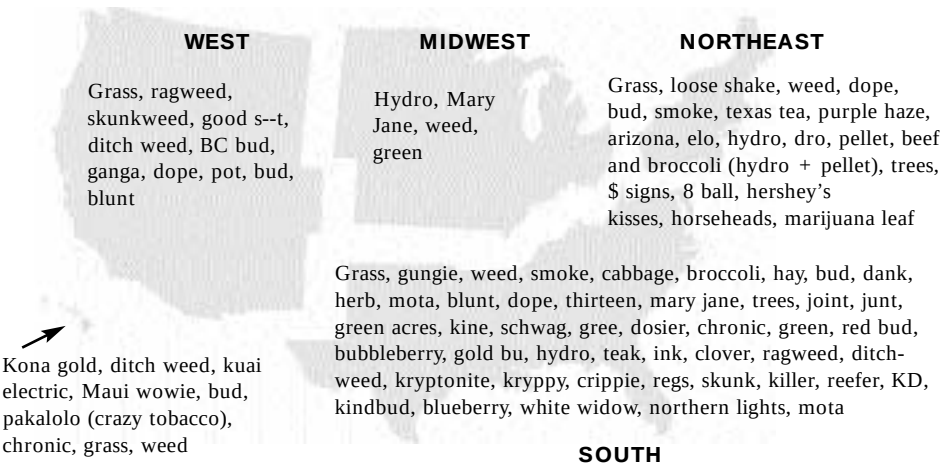
How is marijuana packaged and marketed? As reported in the last *Pulse Check*, the most common marijuana packaging in *Pulse Check* cities is plastic zipper or sandwich bags. Additional packaging includes loose joints in Baltimore and Portland (ME); manilla envelopes, aluminum foil, and plastic wrap in New York; plastic coin zipper bags with logos in Philadelphia; balloons in Denver; and blunts in Washington, DC. No new packaging was reported since the last *Pulse Check*.

## MARIJUANA: THE SELLERS

How are street-level marijuana sellers organized? In most *Pulse Check* cities, independent sellers are the norm, according to law enforcement respondents. Conversely, in Portland (ME), where major local growers organize out-of-State and local distribution of the drug, most sellers are organized. In four cities, independent and organized distribution networks are mentioned: El Paso, Los Angeles (where organized distributors are affiliated with Mexican cartels), St. Louis, and Seattle. Epidemiologic and ethnographic respondents report organized distribution networks more frequently than do their law enforcement counterparts: most marijuana sellers are organized in Baltimore, Denver (where they are Mexican nationals), Detroit, El Paso, Honolulu (where they are loosely organized groups of two to three "runners" and often affiliated with Mexican nationals), and New Orleans (where they are organized loosely). Additionally, the epidemiologic sources in Chicago and St. Louis report marijuana sellers as both organized and independent.

How is street-level marijuana sold? Marijuana distribution methods continue to vary widely. All (21) law enforcement respondents report marijuana as sold hand-to-hand through acquaintance networks; most also report the use of beepers and delivery-type services. Epidemiologic respondents also report hand-to-hand sales, and most report that these sales occur via acquaintance networks. Moreover, beeper and cell phone use is also reported by epidemiologic sources in Chicago, El Paso, Memphis, Miami, New Orleans, New York, and Sioux Falls, and delivery-type methods are reported in

**Exhibit 5.**
**How is marijuana referred to in different regions of the country?**




*Sources: Law enforcement, epidemiologic, ethnographic, and treatment respondents*

**Then and Now:**

**How have marijuana sellers and sales changed (fall 2000 vs spring 2001)?**

*The marijuana sales scene has remained relatively stable since the last* Pulse Check *report. Only a few changes are reported, with no discernible regional trends:*

**Baltimore, MD:** ➤ Marijuana sellers are increasingly younger, according to the law enforcement source.

**Los Angeles, CA:** ➤ The use of electronic equipment, including cell phones, in marijuana sales has increased, according to the law enforcement source.

**Honolulu, HI, and New York, NY:** ➤ According to law enforcement sources, ecstasy sold with marijuana is new this reporting period.

**Miami, FL:** ➤ The law enforcement source reports that marijuana grown indoors and hydroponically is increasing, perhaps due to drought in the region.

**New York, NY:** ➤ According to the epidemiologic source, as marijuana, especially hydroponically grown marijuana, continues to be available, new brand names have appeared.

**Portland, ME:** ➤ The law enforcement source states that marijuana sellers are becoming more organized and the amount sold has increased.

**Washington, DC:** ➤ The epidemiologic source states that marijuana's presence on the drug market has increased.

Birmingham, Chicago, Denver, El Paso, Miami, New York, and Washington, DC. Additionally, in New York, marijuana is often delivered to offices, and in Philadelphia, it is sold primarily hand-to-hand on street corners.

How old are street-level marijuana sellers? Marijuana sellers are predominantly young adults (18–30 years), according to most law enforcement, epidemiologic, and ethnographic respondents across *Pulse Check* sites, but ages vary widely. For example, all age groups are equally likely to sell the drug in Billings, Memphis, and Portland (ME), according to law enforcement sources there. The Baltimore law enforcement and epidemiologic sources report adolescents (13–17 years) as the predominant sellers, and they are split evenly between adolescents and young adults, according to five sources: the law enforcement sources in Birmingham, Los Angeles, and New Orleans; and the epidemiologic sources in Chicago and Detroit. As in many other cities, Memphis has a wide diversity in the age of sellers: marijuana sellers there are predominantly young adults, but some are as young as preadolescents (<13 years), according to the epidemiologic source.

What other drugs do marijuana dealers sell? According to 11 of 21 law enforcement sources, marijuana sellers sell other drugs, most commonly (and as reported in the last *Pulse Check*) crack and powder cocaine (in Birmingham, Columbia [SC], Detroit, Honolulu, Los Angeles, New York, and St. Louis). Additionally, methamphetamine is sold with marijuana in Billings, Honolulu, and Memphis; ecstasy in Honolulu, Miami, and New York; heroin in New York; and PCP in New Orleans. Marijuana sellers typically do not sell other drugs in Baltimore, Boston, Chicago, Denver, El Paso, Philadelphia, Portland (ME), Seattle, Sioux Falls, and Washington, DC.

Similarly, according to 8 of 14 epidemiologic and ethnographic respondents, marijuana sellers typically sell other drugs, including crack cocaine in five cities (Denver, Detroit, New Orleans, New York, and St. Louis), heroin in four cities (Baltimore, Denver, New York, and St. Louis), powder cocaine in two cities (Denver and New York), and methamphetamine in Denver. In Memphis, any drug available may be sold with marijuana. In St. Louis, many dealers, especially those affiliated with gangs, run a "one-stop shop," selling heroin, crack, and marijuana, as reported in earlier sections.

Do marijuana sellers use their own drug? As reported in the last *Pulse Check*, according to nearly all law enforcement and epidemiologic respondents, marijuana sellers are very likely to use the drug. Only the Denver and Honolulu epidemiologic sources report that marijuana sellers are not very likely to use the drug.

Are street-level marijuana sellers involved in other crimes? Nearly all law enforcement, epidemiologic, and ethnographic respondents view marijuana sellers as not very likely or somewhat likely to be involved in other crimes, although law enforcement respondents generally report higher crime levels than their epidemiologic counterparts. The most common type of other crime associated with marijuana sellers is nonviolent criminal acts, such as property damage and burglary. Additionally, gang-related crimes are mentioned in nine cities (Baltimore, Birmingham, Detroit, El Paso, Honolulu, Los Angeles, Memphis, St. Louis, and Washington, DC), violent crimes are mentioned in five (Baltimore, Los Angeles, Memphis, St. Louis, and Washington, DC), and prostitution is mentioned in three (Baltimore, El Paso, and Memphis).

Where is marijuana sold? According to law enforcement, epidemiologic, and ethnographic respondents, marijuana sales are widespread. Most (14 of 21) law enforcement respondents report that marijuana is sold in all areas of cities (central, suburban, and rural), four (in Chicago, Columbia [SC], Honolulu, and Washington, DC) report that it is sold mostly in central city areas, and three (in Baltimore, Los Angeles, and New Orleans) report that it is sold in central city and suburban areas. Similarly, four epidemiologic sources (in Birmingham, Denver, St. Louis, and Washington, DC) report that marijuana is sold in all areas of cities, four (in Baltimore, Honolulu, New York, and Portland [ME]) report that it is sold primarily in the central city, and two (in Chicago and Detroit) report its sale in the central city and suburbs. Additionally, suburban areas are the primary sales location in Sioux Falls, and rural areas are in El Paso, according to epidemiologic sources.

Marijuana is sold both indoors and outdoors, according to all (21) law enforcement sources; epidemiologic respondents tend to agree. According to law enforcement respondents, marijuana is sold in a wide variety of specific settings, most commonly streets and inside cars (mentioned by all sources), public housing developments, private residences, around junior high and high schools, and in nightclubs. Epidemiologic and ethnographic sources agree that marijuana is sold in a wide variety of settings, most commonly private residences and streets.

## MARIJUANA: THE USERS

How old are marijuana users? *(Exhibit 6)* As reported in the last *Pulse Check* issue, adolescents (13–17 years) outnumber the young adult (18–30 years) and older adult (>30 years) user groups in eight *Pulse Check* cities: Baltimore, Columbia (SC), Denver, El Paso, Los Angeles, New Orleans, Portland (ME), and Sioux Falls (according to epidemiologic and ethnographic respondents). Adolescents and young adults are equally likely to be the predominant user group in Seattle. Young adults, however, are named as the largest group of marijuana users in eight cities: Billings, Birmingham, Chicago, Memphis, Miami, Philadelphia, St. Louis, and Washington, DC. Older adults are mentioned only in Detroit (where they equal young adults as the predominant user group), in Honolulu (where all three groups are equally represented), and in Boston. Since the last *Pulse Check* reporting period, the Memphis and Los Angeles sources note a slight increase among young adults, and the Boston source notes an emerging adolescent group, with an age of initiation typically between 14 and 16 years. A longer term trend is noted in Birmingham, where the young adult group has been steadily increasing for the past decade, in tandem with a decrease in crack use.

In the majority of non-methadone programs, the clients most likely to use marijuana are young adults. Preadolescents, however, are named as the predominant marijuana user group in two non-methadone treatment programs (in Baltimore and Portland [ME]), and adolescents are named in another three programs (in Chicago, Columbia [SC], and Sioux

**How have marijuana users changed across the country (fall 2000 vs spring 2001)?**

***According to epidemiologic and ethnographic sources....***

| | |
|---|---|
| *Several increases are noted in various age groups:* | ➤ **Boston, MA:** Adolescents (13–18 years) are an emerging group.<br>➤ **Detroit, MI:** Young adults (18–30 years) have been increasingly using marijuana, so that they now equal older adults (>30 years) as the groups most likely to use the drug. Moreover, adolescents have been emerging as a user group.<br>➤ **Los Angeles, CA:** Adolescents constitute the largest user group, but young adults have increased slightly.<br>➤ **Memphis, TN:** Young adults (18–30 years), the predominant marijuana user group, have increased even more.<br>➤ **Sioux Falls, SD:** Adolescents constitute the largest user group, but the number of preadolescent users (<13 years) has increased.<br>➤ **Washington, DC:** Young adults (18–30 years) constitute the largest user group, but older adults (>30 years) have increased. |
| *An increase in female marijuana users is noted in two cities:* | ➤ **New Orleans, LA**<br>➤ **Philadelphia, PA** |
| *Racial/ethnic distributions have shifted in a few cities:* | ➤ **Memphis, TN:** White marijuana users have increased.<br>➤ **Sioux Falls, SD:** An increase in marijuana use among middle school students (sixth through eighth grades) is reported among recent immigrants from Ukraine, Russia, and various African tribes. This large new population base bears watching for other emerging drug issues, especially among those of student age.<br>➤ **Washington, DC:** Increasing use is noted among Hispanics, but that group is still underrepresented relative to the general population. |
| *Drug use patterns have changed in a few cities:* | ➤ **Birmingham, AL:** Marijuana is most commonly smoked in joints. Blunts are becoming passé.<br>➤ **Memphis, TN,** and **New Orleans, LA:** While joints remain the most common vehicle for smoking marijuana, use of blunts has increased.<br>➤ **Honolulu, HI:** The combination of marijuana and PCP is a recent development.<br>➤ **Philadelphia, PA:** A new practice, still rare, is reported: crushing and sprinkling the diverted prescription drug Xanax® (alprazolam) onto marijuana. |

***According to treatment sources...***

➤ *Novice use of marijuana has remained relatively stable,* but increases are reported in one methadone program (in **Portland, ME**) and in four non-methadone programs: in **Billings, MT; Boston, MA; Columbia, SC;** and **New Orleans, LA.**

➤ **Columbia, SC:** The non-methadone treatment source notes an increase in Blacks and Hispanics, an increase in females, and a lower age of first use.

➤ **Honolulu, HI:** The methadone treatment source notes a decline in the number of marijuana/drug combinations.

Falls). In the Los Angeles and Seattle programs, marijuana-using clients are equally likely to be adolescents and young adults. Older adults are named as the predominant group in the Denver program, they equal young adults in the El Paso and Philadelphia programs, and they equal both younger groups in the St. Louis program. The Columbia (SC) non-methadone treatment source notes that the age of first use has become lower since the last *Pulse Check* reporting period.

Marijuana-using clients in methadone programs tend to be older than those in non-methadone programs: older adults are named as the predominant marijuana users in Chicago, Honolulu, Los Angeles, and Washington, DC, as well as in one of the Boston programs.

Both young adults and older adults are the predominant marijuana users in the El Paso and Portland (ME) programs. Only in the Birmingham program are young adults, exclusively, named as the group most likely to use marijuana. In the second Boston methadone program, marijuana users are equally likely to be adolescents, young adults, and older adults. The *Pulse Check* source at that program elaborates that methadone clients generally have been chronic marijuana users since their adolescence, and that marijuana tends to be the one drug they don't give up—sometimes using it daily, sometimes several times a day.

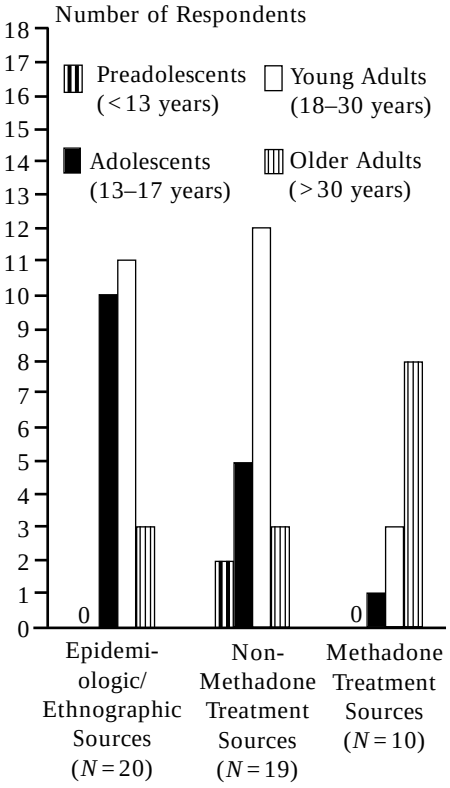
### Why do methadone clients take marijuana?

According to a Boston treatment source, methadone clients sometimes use marijuana daily, sometimes several times a day, for several possible reasons:

- To potentiate the methadone
- To temper their heroin cravings
- As a sleep aid, to counter the impact methadone sometimes has on sleep

**Are there any gender differences in who uses marijuana?** According to epidemiologic and ethnographic sources, males are more likely than females to use marijuana in all but five *Pulse Check* cities. In Boston, Chicago, Portland (ME), Sioux Falls, and Washington, DC, males and females are equally likely to do so. Further breakdowns by age, however, show different gender distributions. In Detroit, for example, older marijuana users tend to be males, but the emerging adolescent group appears evenly split between the genders. Since the last *Pulse Check* reporting period, an increase in female marijuana users has been noted in New Orleans and Philadelphia.

**Exhibit 6.**
**What age group is most likely to use marijuana?**




*Note: In some cities, more than one age group is named.*

In the treatment population, more than in the population described by epidemiologic and ethnographic sources, both genders are equally likely to use marijuana. Such is the case in 11 non-methadone programs: in all five cities in the West, in both Sioux Falls programs, and in Memphis, Philadelphia, Portland (ME), and Washington, DC. Males predominate in the remaining nine programs where this information was provided. In the Columbia (SC) program, where males are the predominant marijuana users, females have increased since the last *Pulse Check* reporting period. Similarly, in methadone treatment programs, marijuana users are more likely to be evenly split between the two genders (as reported in Chicago, Honolulu, Los Angeles, New Orleans, Portland [ME], and one of the Boston programs) than to be primarily males (as in Birmingham, El Paso, Washington, DC, and the second Boston program).

**Is any racial/ethnic group more likely to use marijuana?** As noted in the last *Pulse Check* issue, the marijuana problem cuts across all racial/ethnic groups. Nine epidemiologic and ethnographic respondents (in Billings, Birmingham, Chicago, El Paso, Philadelphia, Portland [ME], St. Louis, Seattle, and Sioux Falls) report that racial/ethnic distributions are fairly representative of their respective cities' populations. White users are more prominent in the Midwest (in Detroit, Sioux Falls, and St. Louis), in the West (in Billings, Denver, Los Angeles, and Seattle), and in Memphis, Miami, and Portland. The Los Angeles epidemiologic source adds that Whites, who now trail Hispanics in Los Angeles' general population distribution, are nevertheless the most likely to use marijuana. In Birmingham, Whites and Blacks are equally likely to use marijuana. Blacks are more likely than other racial/ethnic groups to use marijuana in six cities: Baltimore, Chicago, Columbia (SC), New Orleans, Philadelphia, and Washington, DC. In Honolulu, Asians are the likeliest to use marijuana, but they are underrepresented relative to the general population. While Hispanics are not Philadelphia's largest marijuana-using population, they are overrepresented relative to the general population. The only racial/ethnic shift reported by epidemiologic/ethnographic sources since the last *Pulse Check* reporting period is an increase in White marijuana users in Memphis.

Similarly, reports from treatment sources show how the marijuana problem touches all racial/ethnic groups. According to non-methadone treatment sources, marijuana users are predominantly Whites in 9 programs (in Billings, Columbia [SC], El Paso, Los Angeles, Memphis, Philadelphia, Portland [ME], Seattle, and Sioux Falls), Blacks in 11 programs (in Baltimore, Birmingham, Detroit, El Paso, Los Angeles, Memphis, Miami, New Orleans, New York, Philadelphia, and Washington, DC), Hispanics in 4 programs (in Chicago, El Paso, Los Angeles, and Philadelphia), and Asians in 2 programs (in Honolulu and Los Angeles). (Sources in El Paso, Los Angeles, Memphis, and Philadelphia list more than one group as predominant.) The Columbia non-methadone treatment source notes an increase in Black and Hispanic marijuana users since the last *Pulse Check*.

According to methadone treatment sources, Whites are the predominant marijuana users in four programs (in Boston, Honolulu, Los Angeles, and New Orleans), Blacks in three (in Birmingham, Chicago, and Washington, DC), Hispanics in three (in El Paso, Los Angeles, and New Orleans), and Asians in the Honolulu program. (The Honolulu and New Orleans sources list more than one group.)

Is any socioeconomic group more likely to use marijuana? As with race/ethnicity, marijuana use knows no socioeconomic bounds. Epidemiologic and ethnographic sources report that all SES groups are represented relatively evenly among marijuana users in six *Pulse Check* cities: Denver, Detroit, Honolulu, New Orleans, Portland (ME), and St. Louis. Middle SES groups are more likely to use marijuana in seven cities (Billings, Chicago, El Paso, Los Angeles, Memphis, Miami, and Sioux Falls), and low SES groups are named in five (Baltimore, Columbia [SC], New York, Philadelphia, and Washington, DC). The Birmingham source names both low and high SES groups as the most likely to use marijuana, and the Seattle source names low to middle SES groups. No changes are reported since the last *Pulse Check* reporting period.

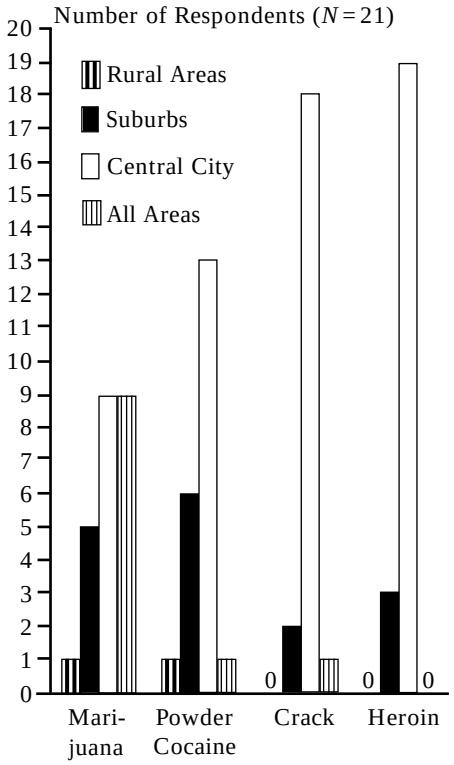
Non-methadone treatment sources, however, paint a somewhat different picture. The majority (in 15 cities) report that marijuana-using clients in their programs are likely to come from low SES backgrounds. Only two (in Denver and Sioux Falls) name the middle SES group, and another two (in El Paso and Los Angeles) name both the low and middle SES groups. St. Louis is the only *Pulse Check* city where marijuana-using clients are equally likely to come from all three (low, middle, and high) SES groups. According to methadone treatment sources, low SES groups predominate in five programs, middle SES groups in two, and both low and middle SES groups in one (Boston); New Orleans is the only city where all three SES groups are named.

Where do marijuana users tend to reside? *(Exhibit 7)* As reported in the last *Pulse Check*, marijuana users, more so than other drug users, reside "everywhere"—a term used by numerous sources to refer to central city, suburban, and rural places of residence. Specifically, epidemiologic and ethnographic sources report all three locations in nine *Pulse Check* cities: Birmingham, El Paso, Miami, and New Orleans in the South; Detroit and St. Louis in the Midwest; and Denver, Honolulu, and Seattle in the West. Suburban residences are more predominant in Billings, Los Angeles, and Sioux Falls, and both suburban and central city residences are reported in Boston and Chicago. central city residences are more commonly reported in the Northeast (in New York, Philadelphia, and—along with rural areas—in Portland [ME]) and the South (in Baltimore, Columbia [SC], Memphis, and Washington, DC). Since the last *Pulse Check*, the El Paso epidemiologic source notes an increase in marijuana users living in rural areas. That shift, however, is probably not due to new use: more likely, it is because more outreach efforts are reaching those areas.

Marijuana users in non-methadone treatment programs are likely to live in central city areas, as reported in 12 *Pulse Check* cities (New York and Philadelphia in the Northeast; Baltimore, Birmingham, El Paso, Miami, New Orleans, and Washington, DC, in the South; Chicago and Detroit in the Midwest; and Billings, Denver, and Los Angeles in the West). They are likely to reside in the suburbs in Columbia (SC), El Paso, Portland (ME), and Seattle, while rural areas predominate in both Sioux Falls programs. Only in Honolulu and St. Louis are clients likely to live in all three types of locations.

According to responding methadone treatment sources, marijuana users in six programs reside predominantly in central city areas (in Birmingham, Boston, Chicago, El Paso, Portland [ME], and Washington, DC), those in Los Angeles live in both central city and suburban areas, and those in a second Boston program live in the suburbs. All three types of locations are named in Honolulu and New Orleans.

**Exhibit 7.**
**Where are drug users most likely to reside?**




*Sources: Epidemiologic and ethnographic respondents*
*Note: Some respondents list two areas per city.*

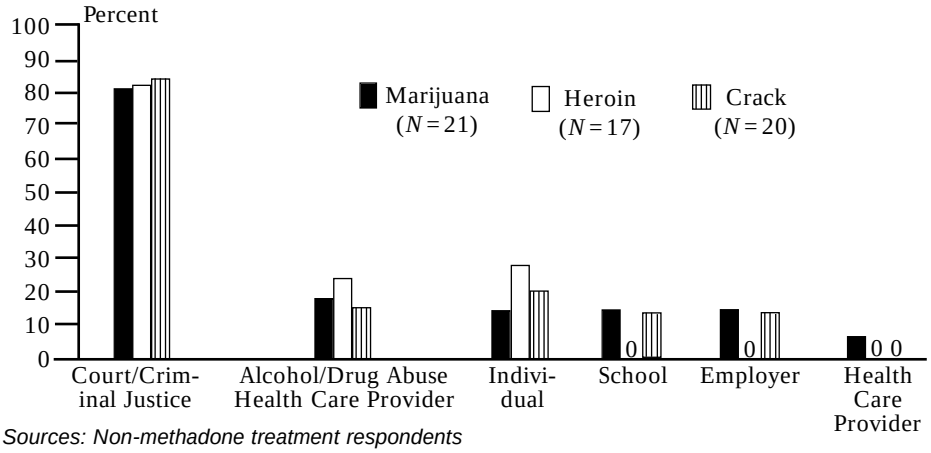
How do marijuana users wind up in treatment? *(Exhibit 8)* The vast majority (17 of 21) of non-methadone treatment sources report that marijuana clients at their programs come mainly from court or criminal justice referrals. These findings differ from those in the last *Pulse Check* in two ways. First, during the last reporting period, the number of marijuana clients exceeded crack and heroin clients in court or criminal justice referrals, whereas during the current period, heroin and crack clients have slightly surpassed marijuana clients in this type of referral. Second, the proportions of clients with criminal justice referrals have increased for all three drugs: from less than 50 percent of responding sources during the last reporting period to more than 80 percent during the current period. These percentages should be viewed with caution because the numbers involved are relatively small and because we cannot generalize *Pulse Check* findings to the general treatment population. That said, these findings make sense in light of the growing legislative trend toward diverting misdemeanor drug abusers out of law enforcement and into treatment.

Comparatively few non-methadone treatment sources list referral sources other than courts or the criminal justice system. Only four list alcohol or drug abuse health care providers (in Memphis, Philadelphia, Portland [ME], and Washington, DC), three name individual referrals (in El Paso, Memphis, and Washington, DC), another three name school referrals (in Baltimore, Chicago, and Columbia [SC]), two name employer referrals (in Honolulu and Washington, DC), and only one (in Memphis) lists other health care providers.

How do marijuana users take marijuana? Joints seem to be the most common vehicle for smoking marijuana, as reported by the vast majority of epidemiologic and ethnographic respondents. However, blunts (hollowed-out cigars filled with marijuana) are more common than joints in Baltimore and Philadelphia, and they are nearly as common as joints in Birmingham, but they are reportedly becoming passé in that city. In some cities, different subgroups of marijuana users prefer different vehicles for smoking marijuana. In Boston, for example, central city residents tend to use blunts, while suburban residents tend to use joints. Similarly, in St. Louis, Blacks who live in the central city tend to use blunts. Increases in blunt use are reported in Memphis and New Orleans, although in the latter city they are not referred to by that term. Pipes and "bongs" are other vehicles for smoking marijuana, as reported in Denver, Miami, and Seattle.

Non-methadone treatment sources report blunts as the predominant vehicle more often than epidemiologic and ethnographic sources. Such is the case in nine programs: in Baltimore, Chicago, Columbia (SC), El Paso, Honolulu, New Orleans, Seattle, Sioux Falls, and Washington, DC.

**Exhibit 8.**
**How are different drug users referred to treatment?**




*Sources: Non-methadone treatment respondents*

Additionally, marijuana users in Birmingham, Boston, Los Angeles, Memphis, and the second Sioux Falls program are equally likely to use blunts and joints. Joints are more common in Billings, Detroit, Miami, New York, Philadelphia, and Portland (ME). Most clients in Denver, and some in Los Angeles and Sioux Falls, tend to smoke marijuana in pipes.

Eight out of nine methadone treatment respondents report that their clients smoke marijuana in joints (in Boston, Chicago, El Paso, Honolulu, Los Angeles, New Orleans, Portland [ME], and Washington, DC). In a second Boston program, however, marijuana smokers are equally likely to use joints, blunts, and bongs.

What other drugs do marijuana users take? *(Exhibit 9)* According to epidemiologic and ethnographic sources, marijuana users often also use crack, sometimes sequentially and sometimes in combination, particularly throughout the Northeast (in Boston, New York, and Philadelphia), the South (in Birmingham, Columbia [SC], El Paso, Memphis, and Washington, DC), and the Midwest (in Chicago, Detroit, and St. Louis). Powder cocaine is sometimes used with marijuana in Memphis, Miami, and Philadelphia. The Boston ethnographic source hears occasional reports about marijuana being mixed with both heroin and cocaine, but has not personally observed such cases. As that source notes, "Heroin users tend not to use marijuana because they have to be on their toes too much." In Philadelphia, some users occasionally crumble and sprinkle the diverted prescription drug alprazolam (Xanax®) onto marijuana; others sometimes mix honey into marijuana to add flavor and "slow the burn." In Miami, marijuana is taken with ecstasy, and in Memphis, marijuana is laced with methamphetamine or amphetamine—a combination that has increased since the last reporting period. PCP lacing or dipping is reported in Boston, Chicago, Honolulu, New Orleans, New York, Philadelphia, and Washington, DC. The PCP combination in Honolulu is a recent development. Elsewhere in the West, the only other drugs mentioned are embalming fluid in Seattle, and club drugs (ecstasy, LSD, and GHB) in Los Angeles.

### Marijuana: First drug of abuse?

According to the Los Angeles epidemiologic source, "Marijuana is not always the precursor to other drug use: now, it sometimes follows club drug use. Some 'rave kids' start by using GHB, then move on to ecstasy, and subsequently end up using marijuana. Some of these users have never even smoked cigarettes."

Marijuana users in several non-methadone treatment programs also take crack. Such reports, like those of epidemiologic and ethnographic sources, occur in the South (in Miami, New Orleans, and Washington, DC) and in the Midwest (in Detroit and Sioux Falls). Unlike epidemiologic and ethnographic reports, no crack use is noted in the Northeast, but two reports emanate from the West (in Billings and Seattle). Marijuana clients in Birmingham, Chicago, Columbia (SC), El Paso, and Los Angeles use powder cocaine. The Birmingham source notes that sometimes the dealer laces the marijuana with cocaine, but with the user's knowledge. PCP use is noted among marijuana clients in Billings, Chicago, Memphis, Miami, Portland (ME), and Washington, DC. In Billings and Chicago, embalming fluid is sometimes added to the marijuana-PCP mixture. Embalming fluid is also mentioned in Birmingham, where some clients soak marijuana in the substance. Marijuana clients in Billings and Sioux Falls sometimes use methamphetamine. Heroin is mentioned only in Philadelphia and St. Louis, but the St. Louis source notes that "Most marijuana users don't use anything else but alcohol. On the other hand, most hardcore drug users also smoke marijuana."

**Exhibit 9.**
**What are some slang terms for drug combinations involving marijuana?**

| Marijuana combined with what drug | Slang Term | City |
|---|---|---|
| Marijuana + crack | Oolies | Boston |
| | Coolies | New York |
| | Diablitos or turbos | Philadelphia |
| | Worties | Washington, DC |
| Marijuana dipped in same water used to cook crack | Elo | New York |
| Marijuana + powder cocaine | Primos | Chicago, El Paso, Los Angeles |
| Marijuana + PCP | Wets | New York, Philadelphia |
| | Love boat | Philadelphia |

*Sources: Epidemiologic, ethnographic, and treatment provider respondents*

In methadone treatment programs, some marijuana clients use crack in Chicago, Los Angeles, and New Orleans. The El Paso source notes that some dealers lace marijuana with heroin or cocaine but that the users are not aware of this practice until they are tested at the clinic. The Honolulu source notes a decline in the number of combinations.

Where and with whom is marijuana used? As reported in the last *Pulse Check*, many epidemiologic and ethnographic sources use the word "everywhere" to describe the settings and contexts of marijuana use. Of 20 sources who discussed this question, 11 report that users are equally likely to smoke the drug both indoors and outdoors, 12 assert that users tend to use it in groups or among friends, and 9 report that users are equally likely to smoke marijuana both in public and in private. Solo use and group use are equally likely in eight cities. For example, in Boston, users report smoking marijuana while alone as a sleep aid or sexual stimulant. However, in no city does any source report that solo use is predominant. The specific settings are as varied as the possibilities—from concerts in Philadelphia to the workplace in St. Louis, from festivals in Denver to outside supermarkets and shopping malls in El Paso, from before and after raves in Miami to around junior high and high schools in 10 *Pulse Check* cities.

Similarly, non-methadone treatment sources frequently report that marijuana users are equally likely to smoke the drug indoors and outdoors, and the majority reports that users tend to smoke the drug in groups or among friends. These sources, however, are about equally divided on the question of public versus private use: clients in Baltimore, Billings, Chicago, Columbia (SC), Honolulu, New York, and Washington, DC, tend to smoke marijuana in public; clients in Birmingham, Detroit, Memphis, Miami, New Orleans, Portland (ME), St. Louis, and Sioux Falls tend to do so in private; and clients in Denver, El Paso, Los Angeles, and Seattle are equally likely to smoke marijuana in public and in private.

Marijuana users in methadone programs, however, have much more discrete use patterns than their counterparts in non-methadone treatment. In the majority of reporting programs, users prefer to smoke marijuana indoors rather than outdoors, and in private rather than in public. These clients, however, still retain the social aspect of marijuana use: no methadone treatment sources report that solo use is predominant over use in groups or among friends.

## MARIJUANA: THE COMMUNITY

### What is the impact of and community reaction to the marijuana problem?

- **Billings, MT:** A new media campaign, targeting both parents and youth, focuses on marijuana and alcohol. The campaign is converting existing ONDCP printed matter into locally relevant messages. Efforts are underway to similarly access and localize ONDCP's Media Campaign messages. Several other recent community prevention efforts include the following: parent seminars; services to under-privileged, high-risk youth, such as mentor programs at Boys' and Girls' Clubs; and programs that focus on Native American youth. It is too early to assess the impact of these efforts, and grant applications are currently being made to sustain them.

- **Hawaii:** After an 8-month halt, the Big Island's Operation Green Harvest marijuana eradication effort was reinstated in April 2001. The epidemiologic source predicts that the amount of "local grow" will go back down, but that this decline will affect the amount of marijuana exported, not the amount consumed locally. Hawaii also has a "Weed and Seed" program, similar to many States' "Drug Free Zones," with stiff sentences for drug arrests around schools.

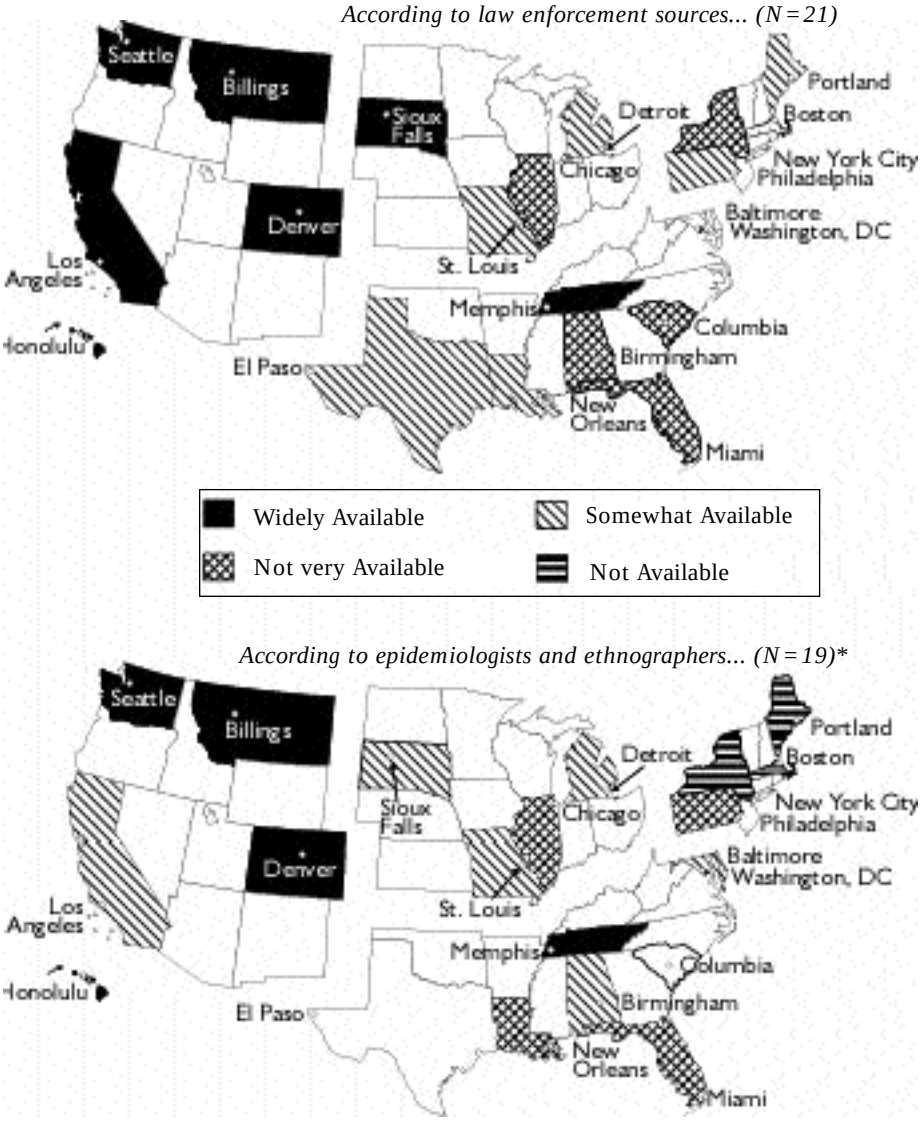
- **Sioux Falls, SD:** The local school district is promoting a parent education program that supports zero tolerance for all drugs. The effort includes letters to parents and billboards about communicating with their children. Anecdotal reports from parents so far suggest that the program is having a positive impact. Additionally, the area has recently completed its first full year of a school-based drug testing program partially funded by the school system. Under this program, parents can sign up their children in advance for random testing and agree to have conversations with them about drugs; alternatively, parents can request one-time tests as they feel necessary. Students from the first category are testing positive at significantly lower levels than those from the second category. Thus, apparently, the parent-child conversations are having an impact, and it is possible that students are using the testing as an excuse not to use the drug.

## METHAMPHETAMINE: THE PERCEPTION

**How do *Pulse Check* sources perceive the methamphetamine problem in their communities, and have their perceptions changed?** Only three sources in two cities (both western) consider methamphetamine the most widely used drug in their communities: the law enforcement source in Billings and the epidemiologic and non-methadone sources in Honolulu. Additionally, nine sources in five cities (all western) consider methamphetamine the second most widely used drug: in Billings (the epidemiologic and non-methadone treatment sources), Denver (the non-methadone treatment source), Honolulu (the law enforcement source), Los Angeles (the non-methadone treatment source), and Sioux Falls (the law enforcement, epidemiologic, and methadone and non-methadone treatment sources). Since the last *Pulse Check* reporting period, no changes were reported in the perceptions of methamphetamine as the most or second most widely abused drug.

More sources report methamphetamine as contributing to the most serious consequences in their communities than report methamphetamine as the most widely used drug. Thirteen sources in four cities (Billings, Denver, Honolulu, and Sioux Falls) report methamphetamine as contributing to the most serious consequences. The Memphis law enforcement source is the only one to report methamphetamine as the drug contributing to the second most serious consequences. Again, since the last *Pulse Check*, no changes were reported in the perceptions of methamphetamine as the drug of abuse contributing to the most or second most serious consequences.

**Exhibit 1.**
**How available is methamphetamine across the 21 *Pulse Check* cities?**




**The epidemiologic and ethnographic sources in Columbia and El Paso did not provide this information.*

## METHAMPHETAMINE: THE DRUG

**How available is methamphetamine across the country?** *(Exhibit 1)* Nearly two-thirds (25 of 42) of law enforcement, epidemiologic, and ethnographic sources report methamphetamine as somewhat or widely available in their communities, and availability varies widely by region. In the West, it considered widely available by nearly every respondent (in Billings, Denver, Los Angeles, Honolulu, and Seattle); in the Midwest, it ranges from not very available (in Chicago) to widely available; in the South, it ranges from not very to widely available; and in the Northeast, it is not very or not available, according to nearly every respondent.

Has methamphetamine availability changed? *(Exhibit 2)* Since the last reporting period, methamphetamine availability increased or remained stable according to all law enforcement, epidemiologic, and ethnographic respondents, with the exception of the law enforcement source in Philadelphia and the epidemiologic source in Boston, who report availability declines. Similar to the last *Pulse Check*, most increases occurred in the South, Midwest, and West, although the percentage of western sources reporting increases this reporting period is lower than the percentage reporting increases last period (50 versus 86 percent).

What type of methamphetamine is available? Locally produced methamphetamine is slightly more available than methamphetamine produced in Mexico, according to law enforcement, epidemiologic, and ethnographic respondents. "Ice," nearly 100 percent pure methamphetamine, is not very available in most cities, except in Honolulu, where it is widely available according to both the law enforcement and epidemiologic sources.

According to most law enforcement, epidemiologic, and ethnographic sources (in Billings, Columbia [SC], Denver, El Paso, Memphis, Portland [ME], St. Louis, and Sioux Falls) most available methamphetamine is produced in "box labs," small, mobile, clandestine labs often located in rural areas. Additionally, methamphetamine labs run by large operations in Mexico and California produce some of the methamphetamine available in Denver, Detroit, Los Angeles, Philadelphia, Seattle, and Washington, DC.

**Exhibit 2.**
**How has methamphetamine availability changed (fall 2000 vs spring 2001)?***

**Increased**

**Billings, MT[L]**
**Birmingham, AL[L]**
**Chicago, IL[L]**
**Columbia, SC[L]**
**Denver, CO[L]**
**Detroit, MI[E]**
**Honolulu, HI[L]**
**Memphis, TN[L]**
**Portland, ME[L]**
**Seattle, WA[L,E]**
**Sioux Falls, SD[L]**
**Washington, DC[L,E]**

**Stable**

**Baltimore, MD[L]**
**Billings, MT[E]**
**Birmingham, AL[E]**
**Boston, MA[L]**
**Chicago, IL[E]**
**Denver, CO[E]**
**Detroit, MI[L]**
**El Paso, TX[L]**
**Honolulu, HI[E]**
**Los Angeles, CA[L,E]**
**Miami, FL[L,E]**
**New Orleans, LA[L]**
**New York, NY[L,E]**
**Philadelphia, PA[E]**
**Sioux Falls, SD[E]**
**St. Louis, MO[L,E]**

**Decreased**

**Philadelphia, PA[L]**
**Boston, MA[E]**

[L] *Law enforcement respondents*
[E] *Epidemiologic/ethnographic respondents*
**The Baltimore, Columbia (SC), El Paso, Memphis, New Orleans, and Portland (ME) epidemiologic/ethnographic sources did not provide this information.*

The manufacturing processes used to produce methamphetamine differ by region. In the Midwest, the "Nazi method" (involving ephedrine or pseudoephedrine, lithium, and anhydrous ammonia) is most often used. In the South and West, both the "cold-cooking method" (involving ephedrine, red phosphorus, and iodine crystals) and the Nazi method are used. In Philadelphia, the "P2P (phenyl-2-propanone) method" (producing a lower purity methamphetamine) is most often used. According to the law enforcement source in Seattle, locally produced methamphetamine is purer than methamphetamine produced in Mexico.

Since the last reporting period, methamphetamine labs have increased in several *Pulse Check* cities, including Detroit, Memphis, Portland (ME), St. Louis, and Sioux Falls. Local box labs or local clandestine labs have increased in Denver, Los Angeles, Memphis, Portland (ME), Sioux Falls, and Seattle. The Portland law enforcement source states that an increasing number of people, typically from the Southwest, are beginning to create methamphetamine labs in that city. The Denver law enforcement source reports that methamphetamine produced by the Nazi method is increasing. The Seattle law enforcement source states that although the number of local box labs has increased, law enforcement officials focus their efforts on the large labs. The Memphis law enforcement source states that more amphetamine is being produced than methamphetamine, and the Denver epidemiologist reports that dietary supplements are often used in the methamphetamine production process.

What are methamphetamine prices and purity levels across the country? *(Exhibit 3)* Reported gram prices (the most common unit of methamphetamine sold) vary widely: $100 in the Northeast (Boston and Philadelphia reporting), $80–$175 in the South, $330 in Chicago, and $20–$300 in the West.

**Exhibit 3.**
**How much does methamphetamine cost in 16 *Pulse Check* cities?**

| | City | Gram price | Ounce price | Purity (%) |
|---|---|---|---|---|
| Northeast | Boston, MA | $100 | NR | NR |
| | Philadelphia, PA | $100 | NR | <25 |
| | Portland, ME | NR | $1,400 | 40 |
| South | Birmingham, AL | $120 | $1,800 | NR |
| | Columbia, SC | $175 | NR | NR |
| | Memphis, TN | $90–$110 | NR | 90–95 |
| | Miami, FL | $80–$100 | NR | NR |
| | New Orleans, LA | $100–$150 | NR | NR |
| | Washington, DC | $140 | NR | NR |
| Midwest | Chicago, IL | $330 | NR | NR |
| | Detroit, MI | NR | $500–$2,000 | 20–25 |
| | Sioux Falls, SD | NR | $800–$1,000 | NR |
| West | Denver, CO | $80–$125 | NR | 20–90 |
| | Honolulu, HI | $200–$300 | NR | NR |
| | Los Angeles, CA | $80–$100 | NR | 15–35 |
| | Seattle, WA | $20–$60 | $350–$650 | 75–95 |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

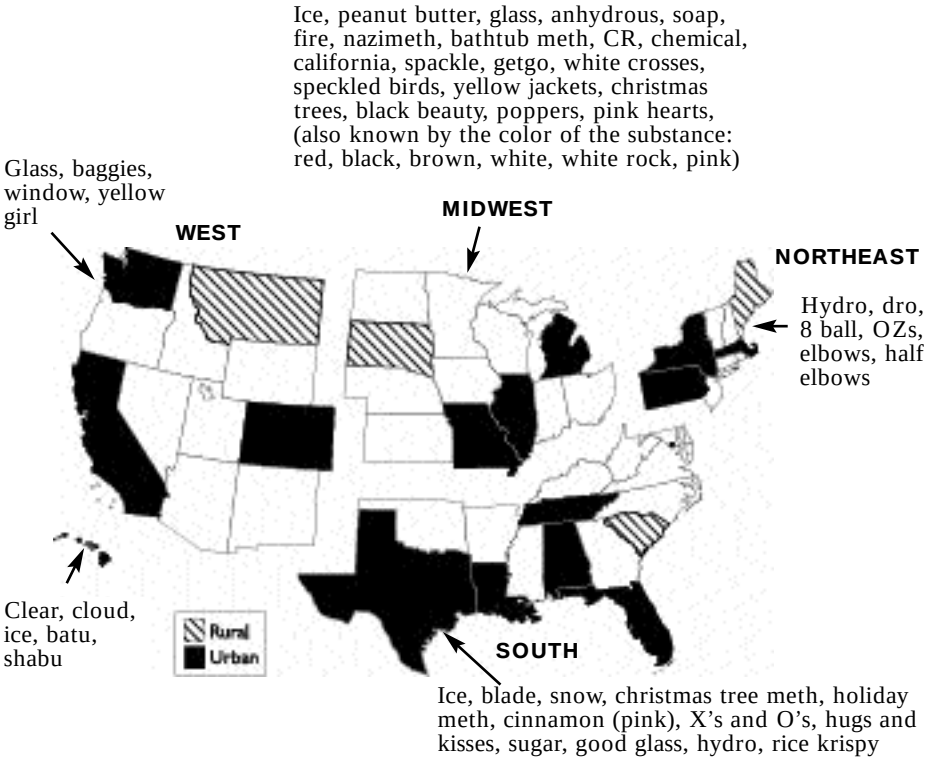
Between fall 2000 and spring 2001, prices remained relatively stable, except in Memphis, where prices declined slightly according to the law enforcement source, and in Chicago, where prices increased according to the law enforcement source.

Methamphetamine purity levels, reported by only seven sources, vary widely, ranging from 15–35 percent in Los Angeles to 90–95 percent in Memphis. Since the last reporting period, purity levels changed in several cities: according to the law enforcement source in Denver and Los Angeles, purity increased, possibly because high-purity methamphetamine produced in local labs by the Nazi method has replaced lower purity methamphetamine produced in Mexico. Similarly, the law enforcement source in Seattle states that the purity of methamphetamine produced in Mexico decreased because it has been diluted with methylsulfonyl methane (MSM) and that locally produced methamphetamine is often of higher purity.

### How is methamphetamine referred to across the country?

*(Exhibit 4)* Across the country, methamphetamine is often referred to as "meth," "speed," "crank," and "crystal." Other slang terms vary by region and tend to be based on the color or consistency of the available methamphetamine, such as "clear," "glass," "yellow girl," and "cinnamon." Often terms are based on production methods: "bathtub meth" refers to methamphetamine manufactured in bathtubs, and "Christmas tree meth" refers to green methamphetamine produced using Drano® crystals.

**Exhibit 4.**
**How is methamphetamine referred to in different regions of the country?**




*Sources: Law enforcement, epidemiologic, ethnographic, and treatment respondents*

How is methamphetamine packaged? According to law enforcement, epidemiologic, and ethnographic respondents, methamphetamine is most commonly packaged in plastic sandwich or zipper bags, as reported in the last *Pulse Check*. Additional types of packaging vary widely: it is packaged in folded paper in Detroit, El Paso, Los Angeles, and Memphis; small coin zipper bags in El Paso, Honolulu, and Washington, DC; tied-off corners of plastic bags in St. Louis and Sioux Falls; cellophane or plastic wrap with duct tape in Denver and Los Angeles; vials in Miami and Seattle; and balloons in Denver. It is sold loose in rock form, like crack, in Birmingham, St. Louis, and Seattle. Few sources in the Northeast responded to this question, in keeping with the lower availability in that region; the widest variety of packaging was reported in the West, corresponding to the wider availability in that region.

## METHAMPHETAMINE: THE SELLERS

How are street-level methamphetamine sellers organized? According to law enforcement, epidemiologic, and ethnographic respondents, methamphetamine sellers are predominantly independent in the Midwest, mostly independent in the Northeast (except in Philadelphia, where biker and organized crime groups are the predominant sellers), and both independent and organized in the South and West. According to the epidemiologist in St. Louis, the affiliation of methamphetamine distributors depends on the source: independent sellers distribute locally produced methamphetamine, and organized sellers distribute Mexican methamphetamine. In Honolulu, sellers are fairly independent with two to three "runners," and some are affiliated with Mexican nationals.

How is street-level methamphetamine sold? According to law enforcement, epidemiologic, and ethnographic respondents, methamphetamine is sold using a variety of methods. The most common are hand-to-hand sales through acquaintance networks. Many sales also involve beeper or cell phone technology (as reported in 12 cities), and in 7 cities (Billings, Birmingham, Denver, Honolulu, Memphis, Philadelphia, and St. Louis), delivery-type services are used.

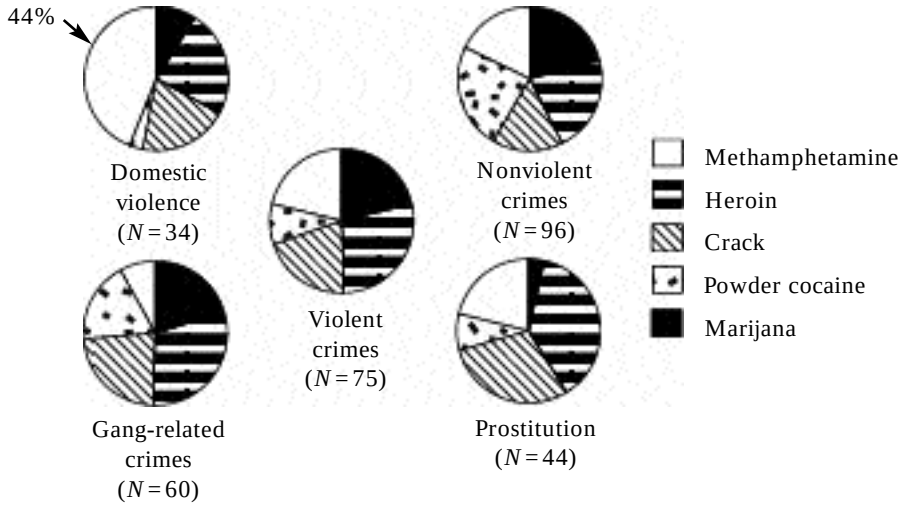
How old are street-level methamphetamine sellers? Law enforcement, epidemiologic, and ethnographic respondents across the Nation report methamphetamine sellers as predominantly young adults (18–30 years), with a few exceptions: according to four sources (the law enforcement sources in Los Angeles, Memphis, and Sioux Falls, and the epidemiologic source in St. Louis), sellers are evenly split between young adults and adults (>30 years), and according six sources (the law enforcement sources in Baltimore, Columbia [SC], Philadelphia, Portland [ME], and St. Louis, and the Billings epidemiologic source), they are mostly adults.

What other drugs do street-level methamphetamine sellers sell? Similar to reports in the last *Pulse Check*, most (13 of 22) law enforcement, epidemiologic, and ethnographic respondents agree that methamphetamine sellers do not typically sell other drugs, but all respondents in the West (5 of 5) report that methamphetamine sellers do sell other drugs, namely heroin, crack and powder cocaine, and marijuana. Additionally, methamphetamine sellers often sell cocaine or ecstasy in Memphis, ecstasy in Miami, and powder cocaine and club drugs (including ecstasy, GHB, and ketamine) in Washington, DC.

Do street-level methamphetamine sellers use their own drug? Most law enforcement, epidemiologic, and ethnographic respondents (15 of 23) report that street-level methamphetamine sellers are very likely to use the drug, as reported in the last *Pulse Check*. Reported levels of likeliness to use the drug are highest among western sources. According to the St. Louis epidemiologist, independent sellers are very likely to use the drug, but organized sellers are not very likely to use the drug.

Are street-level methamphetamine sellers involved in other crimes? *(Exhibit 5)* According to most law enforcement, epidemiologic, and ethnographic respondents, methamphetamine sellers continue to be somewhat involved or very likely to be involved in other crimes, most commonly domestic violence, nonviolent crimes, and other violent crimes. Furthermore, methamphetamine sellers who are organized are reported as more likely to be involved in other crimes than those who are independent. Methamphetamine sellers seem particularly involved in domestic violence: according to 34 law enforcement and epidemiologic respondents, methamphetamine sellers account for 44 percent of the domestic violence among drug sellers, compared with only 24 percent for crack cocaine sellers, 20 percent for powder cocaine sellers, and 9 percent for heroin sellers.

**Exhibit 5.**
**In what other crimes are illicit drug sellers involved, by different drugs, across *Pulse Check* sites?**




*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

Where is methamphetamine sold? *(Exhibit 6)* The geographic location of methamphetamine sales varies widely by region. In the West, except for Honolulu (where sales occur in the central city), respondents agree that sales occur in all areas of the city: suburban, rural, and central. In the Midwest, respondents cite mostly rural areas for methamphetamine sales, except in Chicago, where suburbs are mentioned. In the Northeast, rural areas are mentioned by the law enforcement sources in Boston and Portland (ME), and all areas are mentioned in Philadelphia. Epidemiologists in the Northeast did not respond to this question. In the South, sales settings vary: all areas are mentioned in Birmingham; suburbs are mentioned in Columbia (SC) and

**Exhibit 6.**
**Where is methamphetamine sold and used across 18 *Pulse Check* cities?***

| | City | Streets | | Private Residences | | Private Parties | | Inside Cars | | Night-Clubs | | Raves Concerts | | Public Housing | | College Campus | | Playgrounds/ Parks | | Shopping Malls | | Crack Houses | | Around Supermarkets | | Hotels/ Motels | | Total # Settings | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use |
| *Northeast* | Boston, MA | ✓ | | ✓ | | ✓ | | ✓ | | | ✓ | | | ✓ | | | | ✓ | | | | | | | | | | 6 | 1 |
| | Philadelphia, PA | | | ✓ | ✓ | | ✓ | ✓ | | | ✓ | ✓ | | ✓ | | | | | | | | | | | | | | 4 | 3 |
| | Portland, ME | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | 1 | NR |
| *South* | Birmingham, AL | | | ✓ | | | | ✓ | | | | ✓ | | | | | | | | | | | | | | | | 3 | NR |
| | Columbia, SC | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | 1 | NR |
| | El Paso, TX | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | | | 1 | 9 |
| | Memphis, TN | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | | 12 | 10 |
| | Miami, FL | | | ✓ | ✓ | | | | | ✓ | | ✓ | ✓ | | | | | | | | | | | | | | | 3 | 2 |
| | Washington, DC | | | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | | | | ✓ | | | | | | | | | | | 4 | 5 |
| *Midwest* | Chicago, IL | | | ✓ | ✓ | | ✓ | | | | ✓ | | ✓ | | | | ✓ | | | | | | | | | | | 1 | 5 |
| | Detroit, MI | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | | | | | | | | | | | | | | | | 1 | 4 |
| | St. Louis, MO | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | | | | | | ✓ | | ✓ | | | | | | | | 6 | 2 |
| | Sioux Falls, SD | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | ✓ | | | | | | | ✓ | | | | ✓ | | 8 | 3 |
| *West* | Billings, MT | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | | 12 | 4 |
| | Denver, CO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | 9 | 8 |
| | Honolulu, HI | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | 12 | 2 |
| | Los Angeles, CA | ✓ | ✓ | ✓ | ✓ | | | | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | | | | | | | 2 | 6 |
| | Seattle, WA | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | 8 | 6 |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
**For sales settings law enforcement, epidemiologic, and ethnographic sources responded, except for the following: the law enforcement sources in Baltimore, Chicago, Detroit, New Orleans, and New York, and the epidemiologic sources in Baltimore, Billings, Birmingham, Boston, Columbia (SC), El Paso, Los Angeles, New Orleans, New York, Philadelphia, Portland (ME), and Seattle. For users settings, epidemiologic and ethnographic sources responded, except for the sources in Baltimore, Birmingham, Columbia (SC), New Orleans, New York, and Portland (ME).*

El Paso; the central city is mentioned in Memphis and Washington, DC; and suburbs and the Miami Beach area are mentioned in Miami.

All law enforcement, epidemiologic, and ethnographic respondents in the West report that outdoor and indoor sales are equally common. In the other three regions, indoors sales are generally more common than outdoors sales, but several respondents (in Birmingham, Memphis, Philadelphia, Sioux Falls, and Washington, DC) report that outdoor and indoor sales are equally common. The most frequently mentioned specific sales settings, according to law enforcement, epidemiologic, and ethnographic respondents, continue to be private residences, followed by nightclubs and bars, private parties, and inside cars.

**Then and Now:**

**How have methamphetamine user characteristics changed (fall 2000 vs spring 2001)?**

*According to epidemiologic and ethnographic sources, methamphetamine user characteristics have changed in several areas:*

- **Billings, Detroit, and Washington, DC:** Although adults (>30 years) are the predominant users, young adults (18–30 years) are cited as emerging user groups.
- **Sioux Falls:** Pre-adolescents (<13 years) are cited as an emerging user group.
- **Detroit and Honolulu:** Most methamphetamine users are male, but female methamphetamine users have increased.
- **Los Angeles:** Hispanics and Asian/Pacific Islanders are increasingly using methamphetamine.
- **Washington, DC:** Hispanics are cited as an emerging methamphetamine user group.
- **Los Angeles and Honolulu:** Methamphetamine users who reside in suburban areas have increased.
- **St. Louis:** Methamphetamine users who reside in central city and suburban areas are emerging groups.
- **Honolulu, El Paso, and St. Louis:** Injecting as a route of methamphetamine administration is increasing.

## METHAMPHETAMINE: THE USERS

How have novice methamphetamine treatment clients changed between fall 2000 and spring 2001? Most (9 of 15) non-methadone treatment respondents report that the number of novice methamphetamine users in treatment (defined as any drug treatment client who has recently begun using methamphetamine) is stable, with a few exceptions: novice users increased in Billings, Denver, El Paso, and Sioux Falls; they declined in Portland (ME) and among adolescents in Honolulu. Methadone treatment sources did not provide information on methamphetamine users or methamphetamine treatment clients.

How old are methamphetamine users? *(Exhibit 7)* As reported in the last *Pulse Check*, the predominant age of methamphetamine users varies by city, according to 15 epidemiologic and ethnographic sources, with most (8) reporting young adults (18–30 years) as the predominant users (in Chicago, El Paso, Los Angeles, Memphis, Miami, St. Louis, Sioux Falls, and Seattle). Additionally, four respondents (in Billings, Denver, Philadelphia, and Washington, DC) cite adults (>30 years) as the predominant methamphetamine users, two (in Birmingham and Detroit) cite both young adults and adults, and the Honolulu source cites adolescents and young adults. Based on regions, no patterns in the age of methamphetamine users emerged. Most (8 of 12) non-methadone treatment providers concur that methamphetamine users are predominantly young adults.

Are there any gender differences in who uses methamphetamine? According to most (11 of 15) epidemiologic and ethnographic respondents, methamphetamine users are predominantly male, as reported in the last *Pulse Check*. Only three sources (in Billings, Los Angeles, and Sioux Falls) report methamphetamine users as split evenly between genders, and only in El Paso are methamphetamine users primarily females. By contrast, most (8 of 12) non-methadone treatment respondents report that males and females are equally likely to use methamphetamine; the remaining sources report that users tend to be males.

**Exhibit 7.**
**What age group is most likely to use methamphetamine?***

| | Adolescents (13–18) | Young Adults (18–30) | Adults (>30) |
|---|---|---|---|
| Northeast | | Philadelphia, PA[E,N]<br>Portland, ME[N] | Philadelphia, PA[N] |
| South | Columbia, SC[N] | Birmingham, AL[E,N]<br>El Paso, TX[E,N]<br>Memphis, TN[E]<br>Miami, FL[E] | Birmingham, AL[E]<br>Washington, DC[E] |
| Midwest | Sioux Falls, SD[N] | Chicago, IL[E]<br>Detroit, MI[E]<br>St. Louis, MO[E,N]<br>Sioux Falls, SD[E,N] | Detroit, MI[E] |
| West | Honolulu, HI[E] | Billings, MT[N]<br>Los Angeles, CA[N]<br>Denver, CO[N]<br>Honolulu, HI[E,N]<br>Los Angeles, CA[E,N]<br>Seattle, WA[E,N] | Billings, MT[E]<br>Denver, CO[E] |

[E] *Epidemiologic/ethnographic respondents* [N] *Non-methadone treatment respondents*

**Notes: Epidemiologic sources did not respond in Baltimore, Columbia (SC), New Orleans, and Portland (ME); non-methadone treatment sources did not respond in Baltimore, Boston, Chicago, Detroit, Honolulu, Memphis, Miami, New Orleans, New York, Seattle, and Washington, DC. If respondents cited methamphetamine users as evenly split between two age groups, that respondent is listed under both age groups. Two non-methadone treatment sources from Sioux Falls responded.*

### Is any racial/ethnic or socioeconomic group more likely to use methamphetamine?

As reported in the last *Pulse Check*, methamphetamine users tend to be Whites and overrepresented compared with the general population, according to nearly all (17 of 19) epidemiologic and ethnographic sources. In Billings, they are split evenly between Whites and Native Americans, and in Honolulu, they are be split evenly between Whites and Asian/Pacific Islanders. Most non-methadone treatment respondents agree with their epidemiologic and ethnographic counterparts.

Methamphetamine users continue to be of low or middle SES, with 7 of 16 epidemiologic and ethnographic sources reporting them as having low SES backgrounds and 9 reporting them as being middle SES. All (12) non-methadone treatment respondents concur with epidemiologic sources that users tend to be of low or middle SES.

### Where do methamphetamine users tend to reside?

Depending on the region, the residences of methamphetamine users vary widely. According to epidemiologic and ethnographic sources, most methamphetamine users reside in suburban and rural areas in the Midwest; in central city areas in the Northeast; and in rural areas, suburbs, and central city areas in the South and West. Most non-methadone treatment respondents agree with their epidemiologic counterparts.

### How do methamphetamine users wind up in treatment?

Courts and the criminal justice system are the most common referral sources for clients entering treatment for methamphetamine addiction, according to non-methadone treatment respondents. Individual referrals follow closely as the second most common referral source.

### How do most methamphetamine users take the drug?

Route of administration for methamphetamine varies widely, according to epidemiologic and ethnographic sources. Most (3 of 4) responding sources in the West (in Denver, Los Angeles, and Honolulu) report smoking as the predominant route of administration, but the Seattle epidemiologic source reports oral ingestion as the predominant route. Snorting predominates in three non-western areas (Chicago, Memphis, and Washington, DC), oral ingestion predominates in Miami, and smoking is most common in Sioux Falls and New York. In Philadelphia and Birmingham, snorting and injection are mentioned, in El Paso injection and oral ingestion are mentioned, and in Detroit, snorting and oral ingestion are mentioned. According to the Los Angeles and St. Louis epidemiologic sources, methamphetamine users often switch routes of administration. Most non-methadone treatment respondents agree with their epidemiologic counterparts about predominant route of administration.

### What other drugs do methamphetamine users take?

Methamphetamine users take a variety of other drugs, according to epidemiologic and ethnographic respondents, and as reported in the last *Pulse Check*. The most common

drugs used in combination with methamphetamine are marijuana (in Birmingham, Detroit, Los Angeles, Memphis, Philadelphia, and St. Louis) and ecstasy (in Miami and Washington, DC). Non-methadone treatment sources agree that marijuana is often used in combination with methamphetamine, as reported in Billings, Denver, Los Angeles, Philadelphia, St. Louis, and Sioux Falls.

Where and with whom do methamphetamine users take the drug? *(Exhibit 6)* According to nearly all (17 of 27) epidemiologic, ethnographic, and non-methadone treatment respondents, methamphetamine is generally used indoors and in private. Methamphetamine use is most often a group activity, according to the vast majority (21 of 27) of those respondents. Additionally, the Detroit and Seattle epidemiologic sources and the Philadelphia and Honolulu non-methadone treatment sources report that most methamphetamine users take the drug both alone and in groups; the Miami and Los Angeles epidemiologic sources report that most use the drug alone.

The most frequently mentioned user settings, according to epidemiologic and ethnographic respondents are private residences, followed by private parties and nightclubs. Other common use settings include inside cars and raves and concerts, similar to those reported as sales settings. Moreover, respondents in the South and West report more user settings than those in other regions. Non-methadone treatment respondents also report private residences as the most common setting for methamphetamine use, followed by private parties, inside cars, and parks and playgrounds.

## ECSTASY AND OTHER CLUB DRUGS

The last two issues of *Pulse Check* addressed "club drugs" as a special topic because of reports that these drugs were increasingly available and that the number of users increased. The continuing growth of the club drug problem, particularly ecstasy, has warranted the addition of a club drugs section to the report.

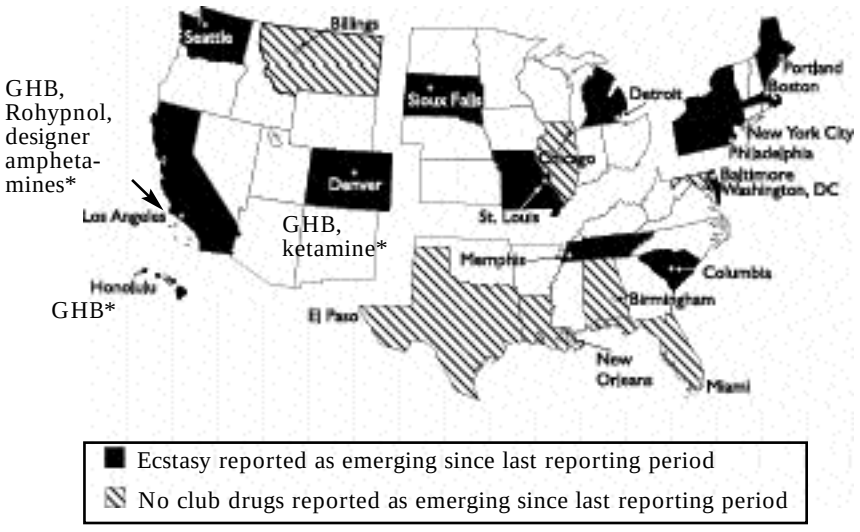
This broad category of drugs includes the following:

- Ecstasy (methylenedioxymethamphetamine, or MDMA), a synthetic, psychoactive substance with stimulant and mild hallucinogenic properties, is the most widely available of club drugs and often used in pill form.
- Gamma hydroxybutyrate (GHB) is a central nervous system depressant usually sold as an odorless, colorless liquid in water bottles. GHB precursors, gamma butyrolactone (GBL) (a chemical used in many industrial cleaners) and 1,4 butanediol (1,4 BD), convert into GHB in the body and have been sold as nutritional supplements in health food stores and over the Internet, often in powder or capsule form. Because the effects of GHB precursors are similar to those of GHB, many *Pulse Check* sources do not distinguish between GHB and its precursors.
- Ketamine is a prescription anesthetic with hallucinogenic and dissociative properties and marketed for human use, but primarily for veterinary use. Ketamine can be used in liquid or powder form.
- Rohypnol (flunitrazepam) is a benzodiazepine, no longer marketed in the United States but legally prescribed in Mexico and other countries. It has been involved in numerous drug-assisted rapes, but its most common abuse pattern is episodic use by teenagers and young adults as an "alcohol extender" and disinhibitory agent.
- Nitrous oxide is an inhalant often referred to as laughing gas.
- Lysergic acid diethylamide (LSD) ("acid") is a hallucinogen, most commonly distributed on blotter paper and taken orally.

The club or rave experience typically involves music, dancing, and socializing and usually lasts through the night. Club drugs are commonly combined with one another and with other illicit drugs or alcohol. As reported in the last *Pulse Check*, treatment sources had less first-hand knowledge of club drug activity than the law enforcement, epidemiologic, and ethnographic sources, indicating that club drug users have not entered treatment in large numbers. It is important to note that the amount of information received from *Pulse Check* sources was much greater for ecstasy than for other club drugs.

Although these drugs are categorized as club drugs, the settings and contexts of their use are expanding to include venues other than nightclubs and raves. Moreover, *Pulse Check* sources continue to suggest that White non-Hispanics are no longer the exclusive sellers and users of the drugs. An increasing number of *Pulse Check* sources report that ecstasy is being sold with heroin and powder and crack cocaine and that ecstasy users are also using these other illicit drugs. Just as *Pulse Check* continues to track club drug activity due to concern about increased availability and use, Federal efforts to combat club drugs (ecstasy in particular) include enacting new Federal sentencing guidelines for ecstasy (MDMA) and ecstasy-like substances (including

**Exhibit 1.**
**Where are club drugs emerging?**




*Sources: Law enforcement, epidemiologic, ethnographic, and non-methadone treatment respondents; methadone treatment sources did not provide information on club drugs.*
**Additional club drugs reported as emerging*

methylenedioxyamphetamine [MDA] and paramethoxyamphetamine [PMA]). The new guidelines, effective November 1, 2001, will increase the prison term for the sale of 200 grams of ecstasy (about 800 pills) from 15 months to 5 years, and the penalty for sale of 8,000 pills will also rise from 41 months to 120 months (similar to that of powder cocaine). *Pulse Check* will continue to track ecstasy and club drug activity and, as new laws are established, will report changes, if any, in the sale and use of club drugs.

## ECSTASY AND OTHER CLUB DRUGS: THE PERCEPTION

**How do *Pulse Check* sources perceive the ecstasy problem in their communities?** Ecstasy is not considered the most widely abused drug by any law enforcement, epidemiologic, ethnographic, or treatment source, but it is considered the second most widely abused drug by sources in four cities (Billings, Honolulu, Memphis, and Miami), an increase from only one source (the Memphis law enforcement source) during the last reporting period. Additionally, the law enforcement source in Billings is the only source to report it as the drug contributing to the second most serious consequences. No other source reports ecstasy as contributing to the most or second most serious consequences in their communities, and no other club drugs were mentioned as such.

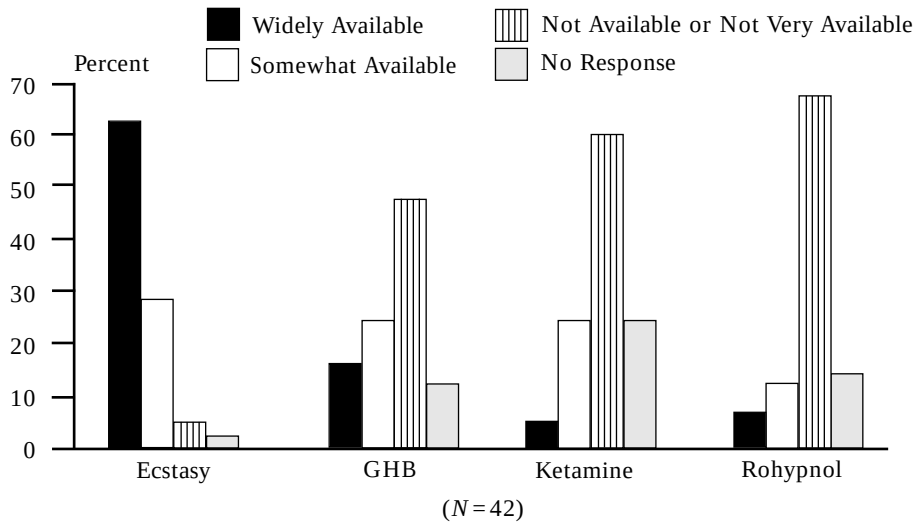
**What club drugs are emerging in *Pulse Check* communities?** *(Exhibit 1)* Although not currently considered the drug contributing to the most serious consequences in any city, ecstasy is reported as an emerging drug of abuse by 25 *Pulse Check* sources in most cities (15 of 21) across the Nation, with no regional patterns evident. Other club drugs mentioned as emerging include GHB in Denver, Los Angeles, and Honolulu; diverted ketamine in Denver; and Rohypnol (flunitrazepam) and designer amphetamines distributed as samples at raves in Los Angeles. In only six cities (Billings, Birmingham, Chicago, El Paso, New Orleans, and Washington, DC) are club drugs not reported as emerging this reporting period. In four of those cities (Chicago, El Paso, New Orleans, and Washington, DC), club drugs were reported as emerging last reporting period, suggesting that these are now established drugs of abuse in those communities.

## ECSTASY AND OTHER CLUB DRUGS: AVAILABILITY, SLANG, AND COMBINATIONS

**How available are club drugs in *Pulse Check* communities?** *(Exhibit 2)* Nearly identical to reports in the last *Pulse Check*, ecstasy remains the most available of club drugs, with more than 90 percent (38 of 42) of law enforcement, epidemiologic, and ethnographic sources reporting it as widely or somewhat available. Only three sources deem ecstasy as not very available: the epidemiologic sources in Billings and New Orleans and the law enforcement source in El Paso. Availability of club drugs is not based on regional patterns.

As reported in the last *Pulse Check*, GHB follows ecstasy as the most available club drug, reported as widely or somewhat available by 40 percent (17 of 42) of respondents. GHB is described as not available in only three cities: Denver, El Paso, and Portland (ME). As reported in the last *Pulse Check*, cities where wide availability is reported are predominantly in the West or South: Billings, Birmingham, Denver, Los Angeles, Miami, New Orleans, and (in the Northeast) New York.

**Exhibit 2.**
**How available are club drugs across the 21 *Pulse Check* cities?**



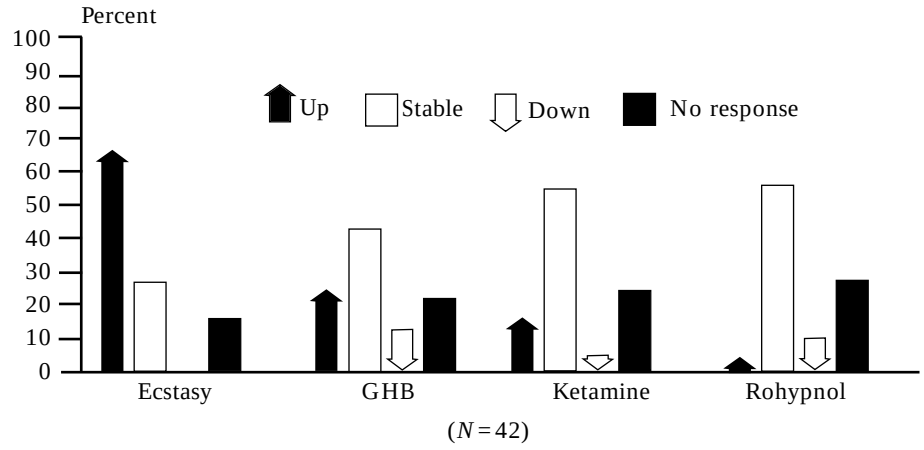

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

Diverted ketamine is considered somewhat or widely available by 29 percent (12 of 42) of law enforcement, epidemiologic, and ethnographic sources, a lower percentage than that reported in the last *Pulse Check*. It is not available in three western areas (Billings, Denver, and Honolulu), El Paso, and Sioux Falls. Rohypnol remains the least available of the club drugs, with 19 percent of law enforcement, epidemiologic, and ethnographic sources reporting it as somewhat or widely available. Three (in Los Angeles, New Orleans, and New York) report Rohypnol as widely available, five report it as somewhat available (in Boston, Detroit, El Paso by both sources, and Seattle), and the rest report it as not or not very available. No regional patterns based on ketamine or Rohypnol availability are apparent.

How has club drug availability changed? *(Exhibit 3)* According to all law enforcement, epidemiologic, and ethnographic sources who discussed this question (38 of 42), ecstasy availability increased or remained stable between fall 2000 and spring 2001, with 64 percent (27 sources) reporting increases, and 29 percent reporting stable trends. As with availability trends for other club drugs, no regional patterns emerged.

GHB availability continues to show mixed trends, according to 42 law enforcement, epidemiologic, and ethnographic sources: 24 percent report increases (in Birmingham, Billings, Chicago, Denver, Memphis, New Orleans, Portland [ME], Sioux Falls, and Washington, DC, according to both sources), 12 percent report declines (in Columbia [SC], Detroit, Honolulu, Miami, and St. Louis), and most report availability as stable. Ketamine availability increased according to sources in Chicago, Columbia, New Orleans, New York, Portland, and Washington, DC; declined according to sources in Honolulu and Miami; and remained stable according to remaining respondents. Rohypnol availability shows mostly stable trends, with few exceptions: the law enforcement sources in New Orleans and Portland report increases, and declines are reported in Birmingham, El Paso, Honolulu, and Miami.

**Exhibit 3.**
**Has club drug availability changed across the 21 *Pulse Check* cities (fall 2000 vs spring 2001)?**




*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

How are club drugs and their combinations referred to across the country ? *(Exhibit 4)* Slang terms for ecstasy are similar across the Nation. It continues to be generally referred to as "X," although "E" and "roll" are also used. The practice of taking ecstasy is often referred to as "rolling." Ecstasy is often referred to by its design or the shape of the pill: for example, it is called "shamrock" in St. Louis because pills may be clover shaped and "Buddha" in Memphis because pills may be stamped with a Buddha design. Other ecstasy terms vary by locality, and many terms are new this reporting period, suggesting increasing ecstasy availability and use.

GHB continues to be referred to as "G" and ketamine as "K" or "special K." Rohypnol is typically referred to as "roofies" and "rochas" where available. Other terms for these drugs vary by locality, with no particular regional patterns. Use of particular combinations of club drugs varies by city and highlights that multisubstance use or "cafeteria-style use" remains common among club drug users.

## ECSTASY: THE DRUG

What form does ecstasy come in? *(Exhibit 5)* According to law enforcement, epidemiologic, and ethnographic sources, the tablet form of ecstasy remains, by far, the most available, followed by powder and liquid forms. Powder ecstasy is widely available according to sources in Boston, Memphis, and Portland

(ME); it is somewhat available according to sources in seven other areas (Baltimore, Birmingham, Columbia [SC], Los Angeles, Miami, Philadelphia, and Washington, DC); and it is not or not widely available elsewhere. The epidemiologic source in Sioux Falls regards liquid ecstasy as somewhat available, and the epidemiologic source in El Paso regards it as widely available. All other respondents report liquid ecstasy as not very or not available.

As reported in the last *Pulse Check* and according to law enforcement, epidemiologic, and ethnographic sources, ecstasy tablets are white or colored, and many are pressed with designs and logos that change periodically. The variety of designs or logos on ecstasy tablets reported has increased dramatically since the last *Pulse Check*. Designs on ecstasy tablets common across the country include "E," "mitsubishi," "mercedes," "playboy," and cartoon characters. Other designs differ according to city. In Columbia (SC), where a variety of stamped tablets are available, some are home pressed. According to the law enforcement source in Denver, designs on ecstasy seized at raves vary widely, but designs on ecstasy seized in large shipments are the same.

How is street-level ecstasy packaged? Overwhelmingly, law enforcement, epidemiologic, and ethnographic sources agree that ecstasy tablets are not typically packaged, but sold as loose (or "naked") pills. Additionally, in Denver, El Paso, Miami, and Portland (ME), pills are packaged in plastic bags; in Birmingham and Denver, they are packaged in prescription bottles; in Billings and Honolulu, they are packaged in

**Exhibit 4.**
**How are ecstasy and ecstasy combinations referred to across *Pulse Check* cities?**

| Drug or drug combination | Slang term | City |
|---|---|---|
| Ecstasy | Tabs | Memphis, New Orleans, and St. Louis |
| | The bean, beans | Birmingham, Denver, and Miami |
| | Beads, ills, and illy | Denver |
| | Candy, **shamrock** | St. Louis |
| | Buddha, eenie greenie, Rolanda, and wafers | Memphis |
| | **Dice** | Columbia |
| | **Disco biscuits** | Birmingham |
| | Sky | Portland |
| | Tuna, X-Files | Washington, DC |
| Two ecstasy pills | Double stacks | Chicago |
| Thick ecstasy pills | Double stacks | Memphis |
| The use of more than one ecstasy tablet at a time | Stacking | St. Louis |
| The use of more than one ecstasy tablet sequentially | Piggybacking | St. Louis |
| Ecstasy (adulterated with amphetamine) | Speedies | Sioux Falls |
| Ecstasy (adulterated with mescaline) | Snackies | Sioux Falls |
| Ecstasy + LSD | Candy flipping | Chicago, Denver, and Philadelphia **(new term and practice in this city)** |
| Ecstasy + LSD | Trolling | Miami |
| Ecstasy +LSD or psilocybin mushrooms | Flipping | Boston |
| Ecstasy + GHB, ketamine, or nitrous oxide | **E sitting, sitting E** | St. Louis |
| Ecstasy + ketamine | Matrix | Chicago |
| Ecstasy + PCP (combined in a pill) | **Pikachu** (also the logo on the pill) | Washington, DC |
| Ecstasy + psilocybin mushrooms | Hippie flipping | Chicago |
| Ecstasy + Xanax® (alprazolam) | Zanybar | Miami |
| Ecstasy + Viagra® (sildenafil citrate) | Hammerheading<br>X's and O's | Miami |
| GHB | Liquid X, liquid E | Boston, Chicago, Denver |
| | Funk, holy water | Denver |
| | Gamma | New Orleans |
| | G juice | St. Louis |
| | Scoop | Birmingham |
| | Water | Sioux Falls |
| Ketamine | Cat | Columbia, Memphis, Washington, DC |
| | Cat food, kitty, vitamin K | Denver |
| | In the K-hole (use of ketamine) | Boston |
| | **Thunder** | Columbia |

*Sources: Law enforcement, epidemiologic, ethnographic, and treatment provider respondents*
*Note: A term in bold face indicates that it is reported as new to the respondent's community since the last reporting period.*

**Exhibit 5.**
**How are ecstasy pills labeled in reporting *Pulse Check* cities?**

| | City | Label |
|---|---|---|
| Northeast | Boston, MA | Mercedes, mitsubishi, and playboy |
| | Philadelphia, PA | Michelin and mitsubishi |
| | Portland, ME | E, various numbers |
| South | Columbia, SC | Diamonds, elephants, mickey mouse, and mercedes |
| | El Paso, TX | E |
| | Memphis, TN | Arrowheads, cartoon characters, flintstone characters, ladybugs, mercedes, teletubbie characters, and VW beetle |
| | Miami, FL | Cartoon characters |
| | New Orleans, LA | Mitsubishi, rolex |
| | Washington, DC | E, animals, **pikachu** (contains PCP) |
| Midwest | Chicago, IL | Ferrari |
| | Detroit, MI | Butterflies, fish, and mitsubishi |
| | St. Louis, MO | Clovers, mitsubishi, playboy, and **statue of liberty** |
| | Sioux Falls, SD | Mitsubishi, nike, suns |
| West | Denver, CO | Cartoon characters, clovers, and stars |
| | Honolulu, HI | **Happy faces, suns, pooh bear, mickey mouse** |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
*Note: A logo in bold face indicates that it is reported as new to the respondent's community since last reporting period.*

plastic coin bags; in New Orleans, they are packaged in plastic logo-emblazoned coin bags, similar to powder cocaine packaging; in St. Louis, they are packaged in cigarette boxes; in Philadelphia, they are strung on necklaces; and in Seattle, they may be concealed in the ends of glow necklaces.

### What are street-level ecstasy prices across the country?

*(Exhibit 6)* The most commonly reported unit of ecstasy sold is one tablet (approximately 100–150 milligrams according to the Miami law enforcement source and 150–250 milligrams according to the Seattle law enforcement source), selling at $12.50–$38 in the Northeast, $20–$30 in the Midwest, $18–$50 in the South, and $20–$45 in the West. Between fall 2000 and spring 2001, according to law enforcement, epidemiologic, and ethnographic sources, prices remained stable, with one exception: according to the law enforcement source in Chicago, prices increased. Other units of ecstasy sold in *Pulse Check* cities include small tablets (50–150 milligrams) for $10–$20 apiece in Seattle, one jar of 100 pills for $3,000 in Sioux Falls, and wholesale units at $6–$18 in New York and $7–$8 in Miami.

**Exhibit 6.**
**How much does a pill (one dose) of ecstasy cost in 17 *Pulse Check* cities?***

| | City | Price |
|---|---|---|
| Northeast | Boston, MA | $20–$35 |
| | New York, NY | $12.50–$38 |
| | Philadelphia, PA | $20–$35 |
| | Portland, ME | $25 |
| South | Birmingham, AL | $20–$35 |
| | Columbia, SC | $20–$35 |
| | Memphis, TN | $20–$35 |
| | Miami, FL | $20–$50 |
| | New Orleans, LA | $25–$35 |
| | Washington, DC | $18–$30 |
| Midwest | Chicago, IL | $20–$30 |
| | Detroit, MI | $25–$30 |
| | Sioux Falls, SD | $30 |
| West | Denver, CO | $20–$25 |
| | Honolulu, HI | $25–$45 |
| | Los Angeles, CA | $20–$30 |
| | Seattle, WA | $20–$30 |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
**Law enforcement, epidemiologic, and ethnographic respondents in Baltimore, Billings, El Paso, and St. Louis did not provide this information.*

### What adulterants are added to ecstasy?

*(Exhibit 7)* Similar to the last reporting period, law enforcement, epidemiologic, and ethnographic sources report that ecstasy may be adulterated with other stimulants or may contain no MDMA. Additionally, according to the epidemiologic source in New York, powder cocaine has been sold as powder ecstasy.

**Exhibit 7.**
**What other substances might be contained in ecstasy tablets?**

| City | Adulterant |
|---|---|
| Boston, MA | Amphetamines, ketamine, LSD, paramethoxyamphetamine (PMA), PCP |
| Denver, CO | Cocaine, heroin, strychnine |
| Memphis, TN | **Depressants**, heroin, **methamphetamine** |
| Miami, FL | PMA |
| Philadelphia, PA | PMA |
| St. Louis, MO | **PCP** (sold as ecstasy and referred to as "space") |
| Sioux Falls, SD | Amphetamine, mescaline |
| Washington, DC | Methamphetamine, **PCP** (tablets with pikachu designs) |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*
*Note: An adulterant in bold face indicates that it is reported as new to the respondent's community since the last reporting period.*

*Pulse Check* sources discuss the wide range of MDMA purity in ecstasy tablets:

- **Boston, MA:** According to the law enforcement source, a lot of phony ecstasy is available, and local manufacturers simply use pill molds to make them. The epidemiologic source agrees and states that ecstasy purity fluctuates wildly, though it may be more consistent for buyers who find regular dealers.
- **Los Angeles, CA:** Ecstasy pills containing adulterants, referred to as "bunk pills," are common, but the epidemiologic source reports that they are no longer seeing pills containing paramethoxyamphetamine (PMA).
- **St. Louis:** According to the epidemiologic source, ecstasy tablet dosage varies greatly due to inconsistent production methods.
- **Washington, DC:** It is becoming harder to obtain pure MDMA tablets, according to the epidemiologic source.

**Then and Now:**

**How have street-level ecstasy sales changed between fall 2000 and spring 2001?**

| | |
|---|---|
| *Ecstasy seller populations are expanding:* | ➤ **Los Angeles, CA:** The law enforcement source states that the number of independent ecstasy sellers has increased.<br>➤ **Memphis, TN:** According to the law enforcement source, ecstasy sellers are expanding to include more high school students.<br>➤ **St. Louis, MO:** According to the epidemiologic source, more adolescents are becoming involved with ecstasy sales, and now about equal numbers of adolescents and young adults sell the drug. |
| *New seller groups include various ethnicities in the Northeast and Blacks in the South in five* Pulse Check *cities:* | ➤ **Birmingham, AL**<br>➤ **Columbia, SC**<br>➤ **Memphis, TN**<br>➤ **New York, NY**<br>➤ **Philadelphia, PA** |
| *Ecstasy sales settings have also expanded in cities across the country:* | ➤ **Birmingham, AL:** The law enforcement source reports that bars and nightclubs are now catering to underage youth. Bars typically have a "rave night" once a week, where no alcohol is sold, but where customers are selling marijuana and ecstasy.<br>➤ **Portland, ME:** Law enforcement sources report an increase in the number of local raves.<br>➤ **St. Louis, MO:** Ecstasy is now more prevalent in high schools and is expanding from raves to schools and from central city areas to suburbs, according to the epidemiologic source.<br>➤ **Washington, DC:** According to the law enforcement source, ecstasy is increasingly sold on the street. |

## ECSTASY: SALES

**Who sells ecstasy?** Young adults are the predominant street-level ecstasy sellers, according to most (20 of 29) law enforcement, epidemiologic, and ethnographic respondents. Five sources (in Birmingham, Denver, New Orleans, St. Louis, and Sioux Falls) report ecstasy sellers as evenly split between young adults and adolescents, and four (in Baltimore, Boston, Memphis, and Seattle) report sellers as primarily adolescents. A summary of ecstasy drug market characteristics appears in exhibit 11 at the end of this section.

Street-level ecstasy sellers tend to be independent, according to most (19 of 30) law enforcement, epidemiologic and ethnographic respondents. Five respondents report ecstasy as organized, and five claim that ecstasy sellers are evenly split between being independent and organized, with organized sellers more involved in raves and nightclub sales than independent sellers. For example, in Denver and Portland (ME), "house dealers" at raves may be in charge of ecstasy sales, with their "runners" distributing drugs to individual buyers; in Miami, organized sellers in clubs tend to be connected with drug trafficking; and in Los Angeles, sellers tend to be affiliated with organized crime. In Columbia (SC) and Denver, independent sellers are college students or those who have access to the college scene.

**Are ecstasy sellers involved in other crimes?** Most law enforcement respondents (13 of 19) report that street-level ecstasy sellers are not typically involved in other crimes. Reports of "somewhat" or "very likely" involved in other crimes are given by six respondents (in Baltimore, Detroit, Portland (ME), Memphis, Miami, and New Orleans). Furthermore, ecstasy dealers are not typically involved in violence, according to 16 of 17 respondents. Only the Baltimore source associates violent crimes with ecstasy sellers. Other crimes associated with ecstasy sellers include drug-assisted rape in Baltimore, Denver, Los Angeles, and Memphis; domestic violence in Baltimore, gang-related activity in Honolulu; and prostitution (users prostituting for the drug) in Birmingham.

Epidemiologic and ethnographic respondents report that ecstasy dealers are less involved in other crimes than do the law enforcement sources. Most (seven of eight) epidemiologic/ethnographic respondents report those selling ecstasy are "not at all" or "not very likely" to be involved in other crimes. Similar to the Baltimore law enforcement response, according to the epidemiologic source, ecstasy sellers are somewhat likely to be involved in other crimes in that city. Other crimes reported by epidemiologic and ethnographic sources are typically nonviolent crimes, although ecstasy sellers are reported to be involved in prostitution and violent crimes in Baltimore and gang-related crimes in Memphis.

**Do ecstasy sellers use their own drug?** Similar to information in the last *Pulse Check*, nearly all (25 of 27) law enforcement, epidemiologic, and ethnographic respondents believe that ecstasy sellers are somewhat or very likely to use the drug. Only in Baltimore (by the epidemiologic source) and Miami (by the law enforcement source) are ecstasy sellers reported as not very likely to use the drug.

**Where is street-level ecstasy sold?** *(Exhibit 8)* According to 20 law enforcement respondents, ecstasy sales take place in a wide variety of areas, mostly central cities and

**Exhibit 8. Where is ecstasy sold and used across the 21 *Pulse Check* cities?***

| | City | Streets | | Raves/ Concerts | | Nightclubs/ bars | | College Campuses | | Private Residences | | Private Parties | | Inside Cars | | Around Schools | | Shopping Malls | | The Internet | Public Housing | | Playgrounds/ Parks | | Total # Settings | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Sell | Use | Sell | Use | Sell | Use |
| Northeast | Boston, MA | | | ✓ | | ✓ | | ✓ | | ✓ | | | | ✓ | | | | | | | | | | | 5 | NR |
| | New York, NY | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | | | | | | 9 | 6 |
| | Philadelphia, PA | | | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | | | | | | | 3 | 2 |
| | Portland, ME | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | | | | | 4 | 3 |
| South | Baltimore, MD | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | | | | 9 | 4 |
| | Birmingham, AL | | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | | | | | | | | | 6 | 3 |
| | Columbia, SC | | | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ | | | | | | | | | | | | 4 | 3 |
| | El Paso, TX | | | ✓ | ✓ | | ✓ | | | | ✓ | | ✓ | | ✓ | | | | | | | ✓ | | ✓ | NR | 7 |
| | Memphis, TN | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | 10 | 6 |
| | Miami, FL | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | | | ✓ | ✓ | | | | 10 | 3 |
| | New Orleans, LA | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | | ✓ | | 12 | 1 |
| | Washington, DC | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | | | | | | 8 | 4 |
| Midwest | Chicago, IL | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | | 5 | 5 |
| | Detroit, MI | | | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | ✓ | | | | | 8 | 3 |
| | St. Louis, MO | | | | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | 8 | NR |
| | Sioux Falls, SD | | | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | | ✓ | | | | | | | | ✓ | | | | 5 | 3 |
| West | Billings, MT | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | 9 | NR |
| | Denver, CO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | | | | | ✓ | 8 | 9 |
| | Honolulu, HI | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | ✓ | ✓ | 11 | 2 |
| | Los Angeles, CA | | | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | | | | | | | | | | 3 | 5 |
| | Seattle, WA | | | ✓ | | | ✓ | | ✓ | | | | ✓ | | | | | | | | | | | | NR | 4 |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

**For sales settings law enforcement, epidemiologic, and ethnographic sources responded, except for the following: the law enforcement source in El Paso and Seattle and the epidemiologic source in Billings, Columbia (SC), El Paso, Los Angeles, Honolulu, New Orleans, Philadelphia, Portland (ME), Sioux Falls, and Seattle. For users settings, epidemiologic and ethnographic sources responded, except for the sources in Billings, Boston, and St. Louis.*

suburbs. Law enforcement sources in six cities (Columbia [SC], Denver, New York, Philadelphia, Portland [ME], and Washington, DC) report ecstasy sales in all areas of the cities. Similarly, according to epidemiologic and ethnographic respondents, the locations of ecstasy sales vary widely, occurring mostly in central city and suburban areas.

Raves and concerts, nightclubs and bars, college campuses, private residences, private parties, and inside cars remain the primary settings for ecstasy sales as reported by law enforcement, epidemiologic, and ethnographic sources. Reinforcing the widespread availability of ecstasy, common sales settings also include schools, streets, shopping malls, and the Internet. Less common settings include public housing developments in Miami, New Orleans, and Sioux Falls; playgrounds or parks in New Orleans and Honolulu; hotels and motels in Columbia (SC); and many types of social gatherings, regardless of setting, in Baltimore.

### Ecstasy sales and user settings: A closer look

The numbers of different ecstasy sales settings and user settings mentioned tend to be larger in the southern and western cities, possibly indicating wider availability and use in those regions.

Ecstasy sales settings tend to overlap with user settings in most cities, but typically more settings are mentioned for sales than for use.

### How is street-level ecstasy sold?

Ecstasy sales typically involve hand-to-hand sales through acquaintance networks, according to most (24 of 29) law enforcement, epidemiologic, and ethnographic respondents. Additionally, beepers or cell phones are used in 10 cities (Baltimore, Billings, Chicago, Detroit, Honolulu, Memphis, Miami, New Orleans, St. Louis, and Washington, DC). According to law enforcement respondents, the drug is distributed by delivery-type services in five cities (Baltimore, Birmingham, Memphis, New Orleans, and St. Louis), and it is sold via the Internet in four cities (Detroit, Honolulu, Memphis, and New Orleans). Conversely, epidemiologic and ethnographic respondents do not report the use of delivery-type services or the Internet for ecstasy sales. According to the Memphis law enforcement source, ecstasy transactions are conducted via introductions; that is, sellers are introduced to potential buyers by a liaison or mutual acquaintance who can vouch for the seller.

### Then and Now:

### What other drugs are sold or used with club drugs (fall 2000 vs spring 2001)?

*Perhaps the most disturbing changes in ecstasy and club drugs activity since the last reporting period are reports in several cities that they are sold and sometimes used with other drugs of abuse, such as heroin and cocaine:*

**Los Angeles:** ➤ Club drugs are becoming the entry point for use of other drugs, such as marijuana, as noted by the epidemiologist. Many "rave kids" in that city start using GHB as part of the "water bottle syndrome," and then move to ecstasy use, followed by marijuana use.

**Memphis, TN:** ➤ The epidemiologic source warns that ecstasy sellers are beginning to sell heroin and powder and crack cocaine. The sale of other illegal drugs by ecstasy dealers may be related to the increasing numbers of young ecstasy users using other drugs of abuse.

**Miami, FL:** ➤ According to the law enforcement source, ecstasy sellers tend to deal in many drugs, including heroin, powder and crack cocaine, and marijuana. As reported in the last *Pulse Check*, the law enforcement source states that heroin and ecstasy sold and used in combination at raves may be a ploy to attract new heroin users. The doses of heroin used in combination with ecstasy are small enough to have little effect; therefore, the user may perceive heroin as harmless.

**New York, NY:** ➤ Ecstasy is sold with other illicit drugs now because selling ecstasy can be extremely lucrative, according to the law enforcement source. Moreover, polydrug sales involving ecstasy are the norm, and ecstasy is actually becoming a currency of trade for other drugs.

**Portland, ME:** ➤ The law enforcement source reports an increase in polydrug sales involving ecstasy.

**Washington, DC:** ➤ Crack cocaine dealers on the street, according to the law enforcement source, are increasingly selling ecstasy.

### What other drugs do ecstasy dealers sell?

According to most (12 of 18) law enforcement respondents, ecstasy sellers also tend to sell other drugs. By contrast, according to most (6 of 8) epidemiologic and ethnographic respondents, ecstasy sellers do not typically sell other drugs. Other drugs sold by ecstasy dealers,

according to law enforcement, epidemiologic, and ethnographic sources, include other club drugs (especially GHB, ketamine, and LSD), heroin, powder and crack cocaine, marijuana, methamphetamine (where it is available), and other diverted prescription drugs. The Philadelphia law enforcement sources states that LSD is often sold as an ecstasy substitute.

## ECSTASY: THE USERS

**How has the number of novice ecstasy users in treatment changed?** *(Exhibit 9)* According to most (9 of 15) non-methadone treatment respondents, the number of novice ecstasy users in treatment (defined as any drug treatment client who has recently begun using ecstasy) has increased since the last reporting period, with the remaining respondents reporting stable trends. Only one methadone treatment source (in Boston) responded to the question, reporting an increasing number of novice ecstasy users in treatment.

**Who uses ecstasy?** Similar to information in the last *Pulse Check*, ecstasy users tend to be young (13–30 years), evenly split between genders, White, and of middle to high SES, according to epidemiologic, ethnographic, and non-methadone treatment sources. In general, methadone treatment sources did not provide information about club drug users.

Of 17 epidemiologic and ethnographic respondents, most (15) report that ecstasy users are predominantly White, and of these, most (13) report that Whites are overrepresented compared with the general population in their cities. Only in Baltimore are Blacks the predominant ecstasy users, but they are underrepresented compared with the general population in that city. In El Paso, Hispanics are the predominant ecstasy users, at proportions about equal to that of the general population. Most ecstasy users range from middle to high SES, according to 18 epidemiologic and ethnographic sources, with 2 exceptions: in Baltimore, predominant users are of low SES, and in Portland (ME), ecstasy users are distributed somewhat evenly among all SES categories. A summary of ecstasy users and use characteristics appears in Exhibit 12 at the end of this section.

**Then and Now:**

**How has ecstasy use changed (fall 2000 vs spring 2001)?**

*Parallel to the expansion of ecstasy sales and seller populations, ecstasy use is expanding to new users groups and new settings in some* Pulse Check *areas:*

| | |
|---|---|
| *Adolescent ecstasy users are increasing in number, according to epidemiologic and ethnographic sources in seven sites across the country:* | ➤ **Columbia, SC**<br>➤ **Los Angeles, CA**<br>➤ **Memphis, TN**<br>➤ **Miami, FL**<br>➤ **St. Louis, MO**<br>➤ **Sioux Falls, SD**<br>➤ **Washington, DC** |
| *Ecstasy use is expanding to non-White and Hispanic populations:* | ➤ **Los Angeles, CA**<br>➤ **Honolulu, HI**<br>➤ **Memphis, TN**<br>➤ **Miami, FL** |
| *Ecstasy use is expanding to new settings and contexts in several sites:* | ➤ **Boston, MA:** Settings for new ecstasy users include streets, public housing developments, and cars, according to the methadone treatment source.<br>➤ **Denver, CO:** According to the non-methadone treatment source, new ecstasy user settings include supermarkets and nightclubs.<br>➤ **Miami, FL:** Ecstasy use is moving from a specific event or place to more common daily use, and some users are beginning to use the drug alone and in private, according to the epidemiologic source. Additionally, private residences, around schools, and private parties were added to the list of user settings. Furthermore, according to the law enforcement source, as ecstasy activity has skyrocketed, the popularity of ecstasy use at raves has shifted to private parties.<br>➤ **St. Louis, MO:** The epidemiologic source states that, in the past, ecstasy use was confined to raves and dance clubs in the central city, but use has moved into the suburbs and into new settings, paralleling increases in adolescent use.<br>➤ **Sioux Falls, SD:** According to the epidemiologic source, more indoor raves are taking place in the area, with increasing advertising and promoting. |

Non-methadone treatment provider respondents (12) agree with epidemiologic and ethnographic sources and report that ecstasy users in treatment tend to be adolescents and young adults, with the Honolulu source reporting the emerging group of ecstasy users in treatment as mostly preadolescents. Also similar to reports by epidemiologic sources, most (8 of 13) treatment respondents state that ecstasy users in treatment are split evenly between genders, and most (8 of 13) report ecstasy users in treatment as predominantly Whites and overrepresented or about proportionate to the general population. Although most treatment respondents (9 of 12) state that ecstasy users in treatment are predominantly of middle SES, two (in Memphis and Billings) report them as predominantly of low SES, and the Los Angeles source reports them as of both low and middle SES. Additionally, in three cities (Boston, New Orleans, and Seattle), emerging ecstasy users in treatment are predominantly of low SES.

Where do ecstasy users tend to reside? According to 18 epidemiologic and ethnographic respondents, locations of ecstasy users' residences differ by region. For example, in the Northeast, ecstasy users reside predominantly in central cities (except in Philadelphia, where they reside in both the central city and suburbs); in the West, they reside predominantly in central cities and suburbs; in the South, they reside in central cities, rural areas, and suburbs; and in the Midwest, they reside predominantly in suburbs (except in Chicago, where they reside in both the central city and suburbs).

**Exhibit 9.**
**Has the number of novice ecstasy users in treatment changed (fall 2000 vs spring 2001)?***

**Billings, MT**
**Boston, MA**
**Columbia, SC**
**Denver, CO**
**Honolulu, HI**
**Memphis, TN**
**Portland, ME**
**Seattle, WA**
**Sioux Falls, SD**

**Miami, FL**
**New York, NY**
**Philadelphia, PA**
**Sioux Falls, SD**
**St. Louis, MO**

*Sources: Non-methadone treatment respondents*
**Sources in Baltimore, Birmingham, Chicago, Detroit, Los Angeles, New Orleans, and Washington, DC, did not provide this information; Billings has two non-methadone treatment respondents.*

Where and in what contexts do ecstasy users tend to use the drug? *(Exhibit 8)* Similar to settings for ecstasy sales, settings for ecstasy use, in descending order of the most frequently mentioned by law enforcement, epidemiologic, and ethnographic respondents, include raves, nightclubs, private parties, private residences, and college campuses. Since the last reporting period, several new user settings have been added to the list, including playgrounds and parks, public housing developments, shopping malls, streets, inside cars, and around schools. Ecstasy use occurs predominantly indoors, according to epidemiologic and ethnographic sources. All 18 respondents report that ecstasy is predominantly used in groups or among friends, but in Miami, ecstasy users are beginning to use the drug alone and in private.

How is ecstasy used and what other drugs do ecstasy users take? Predominant route of administration among ecstasy users remains oral, according to epidemiologic, ethnographic, and non-methadone treatment respondents. Additionally, in Miami and St. Louis, some users are beginning to snort or inject the drug; in New Orleans, it is mixed in beverages; and in Birming-ham and Washington, DC, it is dissolved in hot beverages.

Ecstasy continues to be used in combination with other drugs, including other club drugs (such as LSD, psilocybin mushrooms, GHB, ketamine, and nitrous oxide) across the country; marijuana in the South, West, and Philadelphia; methamphetamine in the West, Memphis, Washington, DC, and Chicago (where the practice is rare); heroin in Memphis, Miami, and St. Louis; powder cocaine in Memphis and Seattle; and diverted prescription depressants in Miami. "Candy flipping," the use of ecstasy and LSD, was mentioned in several areas: Chicago, Denver, Hono-lulu, Memphis, Miami, Philadelphia, and Washington, DC. In Los Angeles and Miami, Viagra® (sildenafil citrate) is used with ecstasy. Exhibit 4 lists slang terms for club drug combinations.

According to non-methadone treatment respondents, the most common club drug combination is ecstasy and marijuana. Emerging combinations include ecstasy and diverted Oxy-Contin® (a time-release, high-dosage

formulation of oxycodone) in Boston; ecstasy and LSD in Columbia (SC); and ecstasy and high-purity methamphetamine ("ice") or cocaine in Honolulu.

In several *Pulse Check* cities Viagra® has recently been reported as sold or used with ecstasy.

- **Honolulu**: Viagra® (sildenafil citrate) is sold with ecstasy or GHB at raves.
- **Miami**: Viagra® used in combination with ecstasy is referred to as "X's and O's" or "hammerheading."
- **Los Angeles**: Viagra® is often used with ecstasy.

## OTHER CLUB DRUGS: THE DRUGS

**What are the common forms of GHB, ketamine, and Rohypnol, and how are they packaged?** The most common form of GHB available is liquid, typically clear, as reported by law enforcement, epidemiologic, and ethnographic respondents. Additionally, a powder form of the drug is somewhat available in New Orleans and Los Angeles. GHB as a liquid is packaged in a variety of ways depending upon locality. Common packaging includes plastic bottles (typically water, sports drink, or soda bottles) in Birmingham, Chicago, Columbia (SC), Detroit, Los Angeles, Memphis, Miami, New Orleans, and St. Louis; eyedropper bottles in Chicago, Los Angeles, and Miami; and vials (glass or plastic) in Billings, Boston, Miami, Philadelphia, St. Louis, and Washington, DC. GBL and 1,4 BD (GHB precursors) are available in some areas, including Boston, Los Angeles, Miami, New Orleans, and Sioux Falls. Many respondents do not distinguish between GHB and its precursors.

### Ecstasy users in treatment: A closer look

The most common treatment referral sources for ecstasy users in treatment, according to 13 non-methadone treatment respondents, are health care providers (in Billings, Columbia [SC], Denver, and Miami), court or criminal justice referrals (in Denver, Miami, St. Louis, and Sioux Falls), and secondary school referrals (in Denver, Los Angeles, and St. Louis). The non-methadone treatment source in St. Louis comments that most ecstasy users in treatment who were referred by schools were sent to treatment because they were caught with marijuana on school property. Similarly, according to the Boston methadone treatment source, another drug besides ecstasy, typically abuse of diverted OxyContin®, tends to be the primary reason an ecstasy user is in treatment. According to the non-methadone source in Columbia, ecstasy users in treatment initially claim to be addicted to drugs other than ecstasy, but clients often later reveal that ecstasy tends to be their primary drug of use.

Six of 10 non-methadone treatment respondents (in Denver, Honolulu, Memphis, Portland [ME], St. Louis, and Sioux Falls) report that ecstasy clients typically use the drug one to two times per week, three respondents (in Los Angeles, Miami, and Sioux Falls) report that ecstasy clients use one to two times per month, and the source in Columbia (SC) reports that they use three to four times per week. In Honolulu, the frequency of ecstasy use among adolescent clients has increased since the last reporting period.

Diverted ketamine is available predominantly in liquid and powder forms, according to responding law enforcement, epidemiologic, and ethnographic sources. It is typically bought and sold as a liquid and taken orally or converted into powder for snorting. Additionally, the liquid form is injected in Boston, Detroit, and Washington, DC; the drug is available in pill form in Los Angeles and New York; and the liquid form is poured in drinks in Boston. Ketamine is illegally sold primarily by the plastic bag as a powder or by the vial as a liquid. Furthermore, according to the Columbia (SC) law enforcement source, sellers transfer ketamine from prescription vials into plain vials to avoid connection with the pharmacy or veterinary office from which it was stolen. The Memphis law enforcement source states that ketamine powder is sold in foil or in folded paper, and the New Orleans law enforcement source reports that liquid ketamine is sold in plastic soda or sports drink bottles. Ketamine is sold in powder form if it is used in clubs and raves in Washington, DC, and in liquid form if it is to be delivered outside of the District, according to the law enforcement source.

Rohypnol is available in pill form, according to respondents in all areas where it is available, and is sold as loose pills, except in New Orleans (according to the law enforcement source), where it is packaged in plastic bowls or small plastic bags.

**How much are GHB, ketamine, and Rohypnol across the country?** *(Exhibit 10)* Where available, GHB sells primarily as a liquid by the dose, with a dose usually comprising bottle capfuls or drops. One dose (a "shot" or "swig") costs $5–$20 in *Pulse Check* cities. Additionally, in Birmingham, dealers are putting GHB in water guns, and users are paying for it by the squirt. In Miami, candy, typically lollipops, is dipped in GHB and sold. In

Columbia (SC), a product containing GHB (liquid Verve®) was given away as a promotional item in a nutritional supplement store. In Miami, a 32 ounce bottle of GBL or 1,4 BD sells for $40–$70. Reported prices for GHB have remained stable since the last reporting period, except in Los Angeles, where they have dropped due to increased availability.

The prices for diverted ketamine vary based on the form of the drug and unit available. Prices have remained stable since the last reporting period, with two exceptions: increases due to decreasing availability are reported in Los Angeles and Portland (ME). Rohypnol prices are reported in only five cities (Chicago, El Paso, Los Angeles, Memphis, and New Orleans) and range widely (from $1 to $25), but have not changed since the last reporting period.

## OTHER CLUB DRUGS: THE SALES

### Who sells other club drugs, and how and where are they sold?

*(Exhibit 11)* According to most law enforcement, epidemiologic, and ethnographic respondents, GHB, ketamine, and Rohypnol sellers and sales characteristics are similar to those of ecstasy, with a few differences, as shown in Exhibit 11.

## OTHER CLUB DRUGS: THE USERS

### Who uses GHB, ketamine, and Rohypnol and where are the drugs used?

*(Exhibit 12)* Regardless of the specific drug and similar to seller characteristics, club drug user characteristics are similar, with a few key differences noted in Exhibit 12.

**Exhibit 10.**
**How much do GHB, diverted ketamine, and Rohypnol cost?**

| City | Most Common Unit Sold | Price |
|---|---|---|
| **GHB** | | |
| Birmingham, AL | 1 ounce | $60 |
| Boston, MA | Capful | $5 |
| Chicago, IL | Capful | $15–$20 |
| Denver, CO | Capful | $5–$10 |
| New York, NY | 1 gram | $30 |
| Los Angeles, CA | Capful (one shot) | $5–$20 |
| Memphis, TN | Capful | $20 |
| Miami, FL | One swig or hit | $5–$10 |
| New Orleans, LA | Capful | $15–$20 |
| Philadelphia, PA | One vial (one dose) | $10–$20 |
| Washington, DC | Thimbleful | $10 |
| **Ketamine** | | |
| Boston, MA | 1-ounce bottle of liquid | $50 |
| Chicago, IL | One bag of powder | $10–$20 |
| Columbia, SC | ½-ounce liquid vial | $125 |
| Denver, CO | One dose | $25 |
| Detroit, MI | 100 milligrams of liquid | NR |
| Los Angeles, CA | One pill | NR |
| | 0.2 grams of powder | $20 |
| Memphis, TN | 0.1 gram of powder | $10 |
| Miami, FL | One vial | $40 |
| New Orleans, LA | 0.35-gram bag of powder | $15–$20 |
| New York, NY | One pill | $40–$50 |
| Philadelphia, PA | One liquid vial | $10–$20 |
| Portland, ME | 0.3-gram bag | $40 |
| Washington, DC | 1/8 gram of powder | $20 |
| | 150-milligram bag | $25 |
| **Rohypnol** | | |
| Chicago, IL | One pill | $5 |
| El Paso, TX | One pill | $1–$5 |
| Los Angeles, CA | One pill | $6–$10 |
| Memphis, TN | One pill | $5–$10 |
| New Orleans, LA | One pill | $15–$25 |

*Sources: Law enforcement, epidemiologic, and ethnographic sources*

**Then and now:**

**How have GHB, ketamine, and Rohypnol sales and users changed (fall 2000 vs spring 2001)?**

| | |
|---|---|
| *Changes among GHB and Rohypnol sellers are reported by law enforcement sources in a few* Pulse Check *cities:* | ➤ **Birmingham, AL, and New Orleans, LA:** More races and ethnicities are involved in selling GHB.<br>➤ **Los Angeles, CA:** The number of independent GHB and Rohypnol sellers increased.<br>➤ **Washington, DC:** GHB has recently been seized with methamphetamine, suggesting that they may be produced at the same clandestine labs.<br>➤ **Los Angeles, CA, and Memphis, TN:** Adolescent users increased.<br>➤ **Sioux Falls, SD:** A group of high school boys has emerged as users. |
| *GHB use has expanded to new user groups in several* Pulse Check *sites, according to epidemiologic and ethnographic sources:* | ➤ **Los Angeles, CA:** An emerging group of high SES users is reported.<br>➤ **Miami, FL:** Emerging groups include Blacks and central city dwellers. Emerging groups tend to be evenly split between the genders.<br>➤ **New Orleans, LA:** Homosexual males are now the primary GHB users. |
| *Ketamine and Rohypnol use and user characteristics have changed in several* Pulse Check *cities, according to epidemiologic and ethnographic sources:* | ➤ **Boston, MA:** Although ketamine is used predominantly at private residences, the emerging group of users tends to use the drug in nightclubs and bars.<br>➤ **Miami, FL:** Adolescents are an emerging ketamine user group.<br>➤ **Washington, DC:** Young adults are the most likely age group to use ketamine, but adolescents are a growing user population. The drug is usually snorted, but injecting has increased.<br>➤ **Birmingham, AL, and Memphis, TN:** Rohypnol use declined.<br>➤ **Los Angeles:** Rohypnol use increased.<br>➤ **Sioux Falls, SD:** Adolescents are an emerging Rohypnol user group. |

### With what other drugs are GHB, ketamine, and Rohypnol used?

Club drug combinations include GHB with alcohol across the country; with ecstasy in Chicago, Los Angeles, Miami, and Seattle; with marijuana in Birmingham and Miami; and with ketamine in Denver. Ketamine is combined with ecstasy in Chicago, Miami, and Washington, DC; with marijuana in Detroit and Miami; with LSD in Chicago; and with methamphetamine in Birmingham. Rohypnol is combined with marijuana in Birmingham and Miami, LSD and ecstasy in Miami, heroin and powder cocaine in El Paso, where the speedball effect (in this case, Rohypnol, a depressant, and cocaine, a stimulant) is reported to "soften the fall when users are coming down from the high."

**Exhibit 11.**
**What are the predominant characteristics of club drug sellers?**

| Variable | Ecstasy | GHB | Ketamine | Rohypnol |
|---|---|---|---|---|
| Age | 18–30 years | 13–30 years | 13–30 years | 13–30 years |
| Organization | Independent | Independent | NR | NR |
| Sales method | Hand-to-hand through acquaintance networks | | NR | NR |
| Likeliness to be involved with other crimes or violence | Not likely | Not likely, with the exception of drug-assisted rape | Not likely, with the exception of veterinary clinic thefts to obtain the drug | Somewhat likely especially especially drug-assisted rape and nonviolent crimes |
| Likeliness to use the drug | Somewhat or very likely | Somewhat likely | Somewhat or very likely | Not very likely |
| Indoors or outdoors | Indoors and outdoors | Indoors | Indoors | Indoors |
| Most common settings | Raves/concerts, nightclubs, college campuses, and private residences and parties, but vary widely | | Private parties and nightclubs | Raves |
| Likeliness to be sold with other drugs | Somewhat likely, especially with other club drugs and some major drugs | Somewhat likely, especially with other club drugs and marijuana | NR | NR |
| Other | NR | Precursors sold at health food and vitamin stores or gyms | NR | NR |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

**Exhibit 12.**
**What are the predominant characteristics of club drug users?**

| Variable | Ecstasy | GHB | Ketamine | Rohypnol |
|---|---|---|---|---|
| Age | 13–30 years | 13–30 years | 13–30 years | 13–30 years |
| Gender | Evenly split | Male | Male | Male |
| Race/ethnicity | Whites and over-represented | Whites and over-represented | Whites and over-represented | Whites and over-represented |
| SES | Middle to high | Middle | Middle | Middle |
| Indoors or outdoors | Indoors | Indoors | Indoors | Indoors |
| Context | In groups/among friends | In groups/among friends | In groups/among friends | |
| Most common settings | Raves/concerts, nightclubs, and private residences and parties, but vary widely | | | |
| Likeliness to be combined with other dugs | Very likely, especially with other club drugs, heroin, powder and crack cocaine, and marijuana | Likely, especially with ecstasy | | Likely, especially with marijuana |
| Other characteristic | Students | NR | NR | Around the Mexican border, users tend to be Hispanic and overrepresented |

*Sources: Law enforcement, epidemiologic, and ethnographic respondents*

## SPECIAL TOPIC: SYNTHETIC OPIOIDS

This *Pulse Check's* special topic discusses the illegal diversion and abuse of synthetic opioids. The topic was selected after several respondents providing information for the last *Pulse Check* issue expressed concern about the diversion and abuse of synthetic opiates, with several specifically citing OxyContin®. The category synthetic opioids was used for the current special topic as it includes a wide range of prescription pain medication, and ONDCP was interested in learning to what extent such medications were being diverted and abused. However, while respondents were asked about the diversion and abuse of synthetic opiods in general for this *Pulse Check*, sources who discussed this emerging issue specifically cited the diversion and abuse of one particular prescription opiate, OxyContin®. As a result, the bulk of this section refers specifically to OxyContin®.

OxyContin® (oxycodone hydrochloride controlled-release) tablets are prescribed to patients suffering from severe persistent pain—a legitimate medical need. However, concern has increased about the diversion and abuse of OxyContin® and other analgesics in some areas of the country. The manufacturer, Purdue Pharma, has been working proactively with law enforcement and the medical community to provide education on the appropriate use of OxyContin® and has recently launched a pilot campaign in several cities to warn youth about the dangers of prescription drug abuse. This special topic section presents findings on the diversion and illegal use or abuse of OxyContin® as reported by *Pulse Check* sources, not on legitimate medical use by patients who use these products at the direction of their physicians.

OxyContin® is the trade name for a high-dose, 12-hour-time-release form of oxycodone, an opoid analgesic, often prescribed for relief from chronic pain and taken orally. Oxycodone is also the active ingredient in other schedule II prescription drugs, such as Percodan®, Percocet® and Tylox®; however, OxyContin® contains a higher concentration of oxycodone (currently 10-, 20-, 40-, and 80-milligram tablets are available) than similar pain relievers.

Since the drug became available in 1996, there have been reports on the diversion and abuse of OxyContin®, especially in rural areas of Northeastern and Southeastern States, such as Kentucky, Maine, Maryland, Pennsylvania, Virginia, and West Virginia, and in rural areas of Ohio. OxyContin® is often referred to by the media as "hillbilly heroin" or "poor main's heroin" for its heroin-like effects and for the initial abuse of the drug in low SES rural areas. These terms, however are misnomers because it is more expensive than heroin when bought illicitly and because its abuse has moved from only lower SES rural areas to include metropolitan areas in 2001.

Reports of crimes committed in order to obtain OxyContin® (such as pharmaceutical burglaries, home invasions, and prescription fraud) and negative health consequences (including deaths, overdoses requiring emergency department visits, and addiction requiring treatment) increased through 2000 and 2001. Although the nonmedical use of OxyContin® was rare in 2000, the most recent (2000) National

*Pulse Check* sources reflect mixed views on the accuracy of media attention:

Although most responding *Pulse Check* sources believe that the media has portrayed the diversion of OxyContin® accurately in their communities, several sources believe that the media has either underplayed or overemphasized the problem. For example, the New Orleans law enforcement source states, "The media hasn't given it (diverted Oxy-Contin®) much media time, but it is a big problem." The Baltimore non-methadone source, the Memphis epidemiologic source, and the Philadelphia non-methadone source agree that the media has underplayed the problem in their communities. However, two sources in Portland (ME) (law enforcement and methadone treatment) state that initially the media underplayed the problem, but that now it is addressed adequately. They also believe that media attention has helped prompt legislation to make it harder to forge prescriptions.

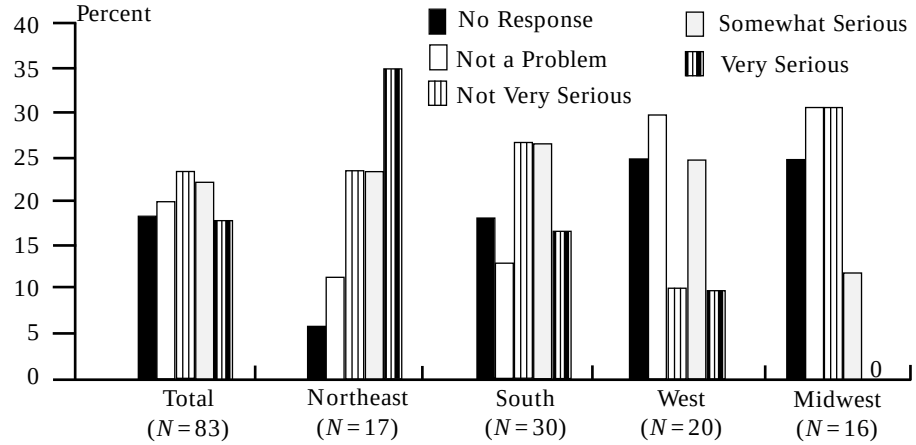
By contrast, many sources (the law enforcement source in Birmingham and Washington, DC; the epidemiologic sources in Boston, New Orleans, Philadelphia, Seattle, and Sioux Falls; and the non-methadone source in Sioux Falls) believe that the media has overemphasized the problem. Several admit that the reason the media might be emphasizing the problem is that "such drugs are very addictive." However, the opinion of several sources is that not only has the media overplayed the problem of diverted synthetic opiates like OxyContin® in their communities, but also they have helped encourage abuse. For example, the Boston epidemiologic source states, "Large amounts of media coverage have probably led to increased use by alerting opiate addicts to a possible market….it has probably increased illicit (OxyContin®) sales." The Portland (ME) epidemiologic source reports that the intense press coverage is accurate for the area, but that media attention "may have increased the value of illicit OxyContin®; it may have increased the desire to obtain it."

Household Survey on Drug Abuse (NHSDA) shows a significant increase ($p < 0.01$) in the number and percentage of lifetime nonmedical use of OxyContin®. Finally, the most recent data from emergency department mentions of the synthetic opiate, oxycodone, which includes OxyContin®, Percocet®, Percodan®, and Tylox®, increased 68 percent (from 6,429 to 10,825) between 1999 and 2000, according to the Drug Abuse Warning Network (DAWN).

In summer 2001, increased reports of abuse of the drug and related crimes prompted the FDA to strengthen warnings and precautions in the labeling of the product. Purdue Pharmaceuticals undertook a number of activities aimed at reducing diversion and abuse, including issuing a warning in the form of a letter distributed widely to physicians, pharmacists, and other health care professionals, and the suspension of sales of the strongest formulation of the tablet (160 milligrams).

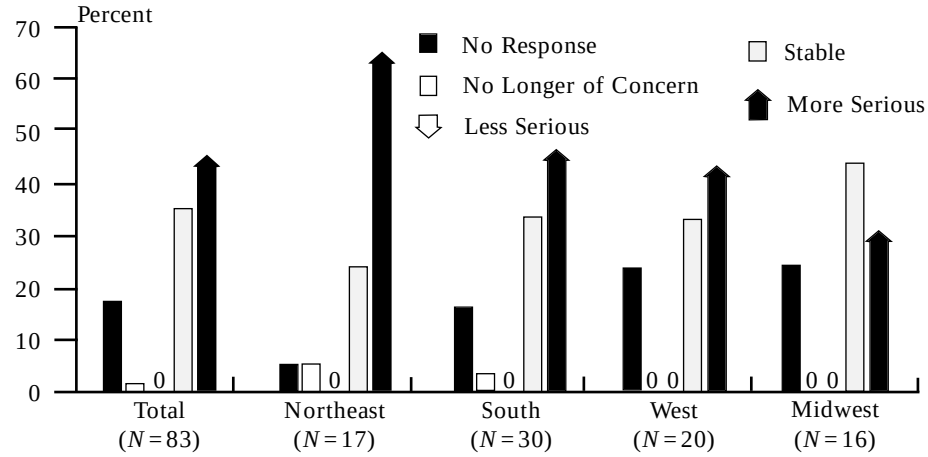
This *Pulse Check* special section corroborates increased levels of OxyContin® diversion and abuse and finds that its diversion and abuse are reported as highest in the Northeast and eastern parts of the South and lowest in the Midwest. Furthermore, sources who provided demographic information about OxyContin® abusers and sellers were mostly from the Northeast and (to a lesser extent) the Southeast, highlighting that it is not yet a large problem in the West and Midwest. This section also supports reports that although OxyContin® diversion and abuse occur mostly in rural areas, they have also recently emerged in metropolitan areas (especially those in the Northeast and Southeast), such as Baltimore, Boston, Denver, Detroit, Miami, Philadelphia, St. Louis, and Washington, DC.

**Exhibit 1.**
**How much of a problem is OxyContin® diversion and abuse, by U.S. region?**




*Sources: Law enforcement, epidemiologic, ethnographic, and methadone and non-methadone treatment repondents*

**Exhibit 2.**
**How has the perceived OxyContin® problem changed since the last reporting period, by U.S. region?**




*Sources: Law enforcement, epidemiologic, ethnographic, and methadone and non-methadone treatment respondents*

## OXYCONTIN®: THE PERCEPTION

**How serious a problem is OxyContin® abuse and diversion in *Pulse Check* cities?** *(Exhibit 1)* Nearly one-third (32 of 83) of *Pulse Check* sources (law enforcement, epidemiologic, ethnographic, methadone treatment, and non-methadone treatment) perceive OxyContin® diversion or abuse as a somewhat serious or very serious problem in their communities, 23 percent (19) perceive it as not a very serious problem, 20 percent (17) perceive it as not a problem, and 18 percent (15) did not respond to the question. Sources in the Northeast perceive OxyContin® diversion and abuse as a more serious problem than in other

regions, with 35 percent of those sources reporting it as a very serious problem and 24 percent reporting it as a somewhat serious problem. Seventeen percent of sources in the South report the problem as very serious, and 27 percent report it as somewhat serious. By contrast, only 10 percent of western sources report it as very serious and 25 percent as somewhat serious; and finally, no midwestern sources report it as very serious and only 13 percent report it as somewhat serious.

**How has the perceived problem changed between fall 2000 and spring 2001?** *(Exhibits 2 and 3)* Nearly half (37 of 83) of *Pulse Check* sources perceive OxyContin® diversion and abuse as escalating in their communities since the last reporting period, and no sources report the problem as declining. As with perceived levels of seriousness, increases in OxyContin® diversion and abuse are largest in the Northeast, with 65 percent of sources reporting increases. Increases were lowest in the Midwest, with 31 percent of sources reporting increases.

Moreover, among sources who report the diversion and abuse of OxyContin® as a very serious problem (in Billings, Birmingham, Boston, Columbia [SC], Honolulu, Miami, New Orleans, Philadelphia, and Portland [ME]), all report an intensification of the perceived problem except in Honolulu, where it remained stable since the last reporting period.

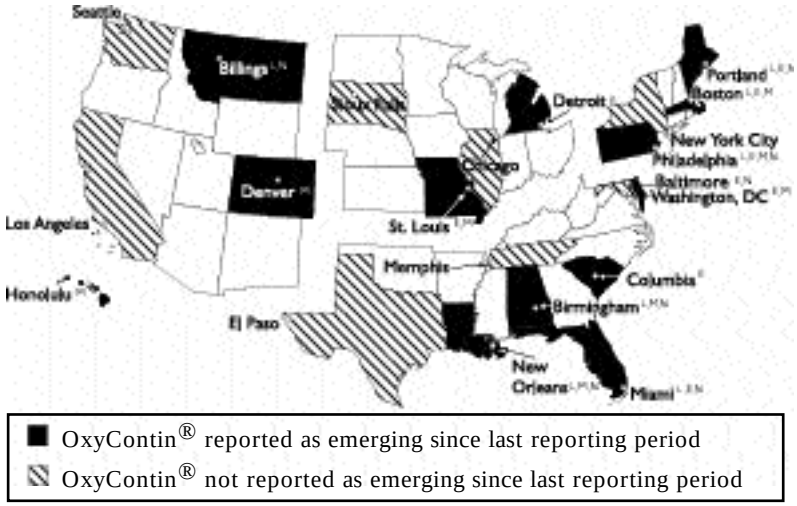
**Where is OxyContin® abuse emerging across the country?** *(Exhibit 4)* More sources (law enforcement, epidemiologic, ethnographic, and methadone and non-methadone treatment) report OxyContin® as the emerging drug of abuse in their communities than any other drug this reporting period. For example, 31 of 84 sources in most (14) *Pulse Check* cities report OxyContin® as an emerging drug of abuse, compared with 25 sources in 15 cities who report ecstasy as an emerging drug of abuse. By stark contrast, in the last *Pulse Check*, OxyContin® was reported as the emerging drug of abuse only by the epidemiologic source in Portland (ME). During this reporting period, more sources in northeastern and southern (especially southeastern) cities report OxyContin® as an emerging drug of abuse than in cities elsewhere.

**Exhibit 3.**
**How serious a problem is OxyContin® diversion and abuse in *Pulse Check* cities and how has the problem changed (fall 2000 vs spring 2001?)***


[L]*Law enforcement respondents*
[E]*Epidemiologic and ethnographic respondents*
[M]*Methadone treatment respondents*
[N]*Non-methadone treatment respondents*

**Information was not provided by law enforcement sources in Los Angeles, St. Louis, and Seattle; epidemiologic sources in Chicago, El Paso, and Honolulu; methadone treatment sources in Detroit, Los Angeles, Miami, New Orleans, and New York; and non-methadone treatment sources in Los Angeles, Memphis, Sioux Falls, and Washington, DC.*

**Exhibit 4.**
**Where is the diversion and abuse of OxyContin® emerging?**




*[L]Law enforcement respondent*
*[E]Epidemiologic/ethnographic respondent*
*[M]Methadone treatment respondent*
*[N]Non-methadone treatment respondent*

## OXYCONTIN®: THE DRUG

**How available is diverted OxyContin®?** *(Exhibit 5)* Across the country, more than two-thirds (18 of 26) of law enforcement, epidemiologic, and ethnographic respondents in 12 cities (Billings, Birmingham, Boston, Chicago, Detroit, Honolulu, Miami, New Orleans, Philadelphia, Portland [ME], Seattle, and Washington, DC) report diverted the OxyContin® as somewhat or widely available. Furthermore, most (17 of 23) respondents report increased availability of the diverted product since the last reporting period, 5 report it as stable, and only 1 (the Portland [ME] epidemiologic source) reports declining availability. In general, sources in the Northeast report higher levels of diverted OxyContin® than those elsewhere.

**How is diverted OxyContin® referred to across the country?** *(Exhibit 6)* Diverted OxyContin® is most often referred to as "oxy" or "OC's," according to law enforcement, epidemiologic, ethnographic, and methadone and non-methadone treatment respondents. Additionally, the pills are referred to as "blues" in Miami, "forties" and "horse pills" in Boston, and "O's" in Philadelphia.

**Exhibit 5.**
**How available is diverted OxyContin® in 17 *Pulse Check* cities, and how has availability changed (fall 2000 vs spring 2001)?***

| | | Law enforcement sources | | | | | | Epidemiologic and ethnographic sources | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | City | No response | Not available | Not very available | Somewhat available | Widely available | Change | No response | Not available | Not very available | Somewhat available | Widely available | Change |
| *Northeast* | Boston, MA | | | | | ✓ | ↑ | | | ✓ | | | ↔ |
| | New York, NY | | | ✓ | | | ↔ | ✓ | | | | | NR |
| | Philadelphia, PA | | | | | ✓ | ↑ | | | | ✓ | | NR |
| | Portland, ME | | | | | ✓ | ↑ | | | | ✓ | | ↓ |
| *South* | Baltimore, MD | ✓ | | | | | NR | | | ✓ | | | ↔ |
| | Birmingham, AL | | | | ✓ | | ↑ | | | ✓ | | | ↑ |
| | Memphis, TN | ✓ | | | | | NR | | | ✓ | | | NR |
| | Miami, FL | | | | ✓ | | ↑ | | | | | ✓ | ↑ |
| | New Orleans, LA | | | | | ✓ | ↑ | ✓ | | | | | NR |
| | Washington, DC | | | | ✓ | | ↑ | | | | ✓ | | ↑ |
| *Midwest* | Chicago, IL | | | | ✓ | | ↑ | | | ✓ | | | NR |
| | Detroit, MI | | | | ✓ | | ↔ | | | | ✓ | | ↔ |
| | Sioux Falls, SD | | | ✓ | | | ↑ | ✓ | | | | | NR |
| | St. Louis, MO | ✓ | | | | | NR | | | ✓ | | | ↑ |
| *West* | Billings, MT | | | | | ✓ | ↑ | ✓ | | | | | NR |
| | Honolulu, HI | | | | | ✓ | ↑ | | | | | ✓ | ↑ |
| | Seattle, WA | | | | ✓ | | ↑ | ✓ | | | | | NR |

**Sources did not provided information in Columbia (SC), Denver, El Paso, and Los Angeles.*

**Exhibit 6.**
**How is diverted OxyContin® referred to in *Pulse Check* cities?**

| Slang Term | City |
|---|---|
| Oxy | Billings, Boston, Detroit, Honolulu, Philadelphia, Portland (ME), Washington, DC |
| OC's | Birmingham, Boston, Miami, Portland (ME) |
| Oxy-cotton | Memphis, Philadelphia |
| Blues | Miami |
| Forties, horse pills | Boston |
| O's | Philadelphia |

*Sources: Law enforcement, epidemiologic, ethnographic, methadone treatment, and non-methadone treatment respondents*

## DIVERTED OXYCONTIN®: SALES

How is OxyContin® diverted and sold illicitly? According to law enforcement sources, OxyContin® is diverted in a variety of ways within *Pulse Check* communities, including fraudulent prescriptions, "doctor shopping," legitimately obtained pills sold illicitly, and pharmaceutical robberies. The most common way to divert the drug (as reported in Billings, Boston, Honolulu, New Orleans, Philadelphia, Portland [ME], Sioux Falls, and Washington, DC) is through filling fraudulent prescriptions: diverted OxyContin® sellers either make their own prescription forms or steal blank prescription pads and write their own prescriptions to obtain the drug. Another frequently reported method of diverting OxyContin® (as reported in Boston, Detroit, New Orleans, Philadelphia, and Portland) is doctor shopping: people, posing as patients, fake legitimate pain to numerous doctors, and doctors prescribe the drug. Often, people who doctor shop use some of the pills obtained through the prescriptions. Patients who obtain and use the drug legitimately, as prescribed by doctors for pain, but sell some of the pills illicitly, are also frequently mentioned by sources (in Birmingham, Boston, Detroit, and Washington, DC). Pharmaceutical robberies are mentioned in Billings, Boston, New Orleans, and Portland (ME). Additionally in Portland (ME), where armed robberies of pharmacies for OxyContin® have increased drastically, doctors and pharmacy employees have been involved in OxyContin® theft and may help plan the robberies. Also in that city, home invasions of clients who have legitimately filled OxyContin® prescriptions have been reported, with the suspicion that pharmacists are involved in obtaining patient information. Finally, in New Orleans, some shipments of the drug are thought to come via U.S. mail from Mexico.

Except in Boston and Miami, epidemiologic and ethnographic sources did not provide information about the sources of diverted OxyContin®. According to the Boston epidemiologic source and in agreement with the law enforcement source in that city, low SES patients with legal OxyContin® prescriptions sell some of the pills illicitly. In Miami, organized diversion efforts are conducted by dealers who recruit patients from substance abuse treatment and mental health facilities. Dealers drive these patients in vans to doctors who prescribe OxyContin®. After the prescriptions have been written and filled, patients return to the vehicles, give most of the pills to the dealers, and keep a few pills for themselves. Dealers often target and recruit methadone and other treatment clients because of their vulnerability to addiction.

Once OxyContin® is diverted, it is sold hand-to-hand, mostly through acquaintance networks, according to law enforcement respondents. Additionally, beepers and delivery-type services are used to distribute the drug illicitly in Billings, Boston, Honolulu, and New Orleans.

What are diverted OxyContin® prices across the country, what are the most common units sold, and how is it packaged? *(Exhibit 7)* Diverted OxyContin® costs $1 per milligram in most cities where law enforcement, epidemiologic, and ethnographic sources responded (in Boston, Chicago, Miami, and Philadelphia). In Billings, prices are $1–$1.50 per milligram, and in Washington, DC, they are $1–$2 per milligram.

The most common pill unit of diverted OxyContin®, according to law enforcement, epidemiologic, ethnographic, and treatment sources, is the 40-milligram tablet, followed by the 20- and 80-milligram tablets. Interestingly, methadone and non-methadone treatment sources report higher milligram units (typically 80 milligrams) sold than their law enforcement and epidemiologic counterparts.

According to eight of nine law enforcement, epidemiologic, and ethnographic respondents (in Baltimore, Boston, Detroit, Miami, Philadelphia, Portland [ME], and Washington, DC), diverted OxyContin® is sold as loose pills. Additionally, law enforcement respondents in Boston and Portland (ME) report that it is sold in prescription bottles, and the Billings law enforcement source reports that it is sold in small zipper coin bags.

**Exhibit 7.**
**What are the most commonly sold units of diverted OxyContin®?**

| | City | Most common unit sold (in milligrams) |
|---|---|---|
| Northeast | Boston, MA | 10, 40 |
| | Philadelphia, PA | 20, 40, 80 |
| | Portland, ME | 20, 40, 80, 160 |
| South | Baltimore, MD | 20, 40 |
| | Birmingham, AL | 80 |
| | Columbia, SC | 40, 80 |
| | Miami, FL | 20 |
| | Washington, DC | 20, 40 |
| Midwest | Detroit, MI | 40, 80 |
| | St. Louis, MO | 40 |
| West | Billings, MT | 20, 40 |
| | Honolulu, HI | 20, 80 |

*Sources: Law enforcement, epidemiologic, ethnographic, methadone treatment, and non-methadone treatment respondents*

How often is diverted OxyContin® available? According to the Portland (ME) law enforcement and epidemiologic sources and the New Orleans law enforcement source, for the past year, OxyContin® has been available continually on the illicit drug market. By contrast, according to epidemiologic sources in Birmingham and Washington, DC, and the law enforcement source in Honolulu, the drug has been available on the illicit drug market only periodically. Other respondents claim that the drug is so new to the illicit drug market that they cannot assess whether the drug is available continually or periodically.

Who sells diverted OxyContin®? According to all (nine) responding law enforcement sources, diverted OxyContin® sellers are independent. The law enforcement sources in New Orleans, Portland (ME), Seattle, and Washington, DC, add that they tend to be heroin addicts or often associate with heroin users.

According to law enforcement, epidemiologic, and ethnographic respondents in Billings, Honolulu, Memphis, Philadelphia, and Washington, DC, diverted OxyContin® sellers tend to be adults (>30 years). Young adults (18–30 years) predominate in two cities: Birmingham and Portland (ME). Furthermore, according to the New Orleans law enforcement source, participants in the club scene are starting to become involved with the sale and use of diverted OxyContin®.

What other drugs do diverted OxyContin® dealers sell? According to all law enforcement, epidemiologic, and ethnographic respondents (11 of 11), diverted OxyContin® dealers sell other drugs, most commonly heroin (as reported in Baltimore, Boston, Honolulu, New Orleans, Portland [ME], and Washington, DC) and other diverted prescription drugs, especially other opiates (as reported in Honolulu, New Orleans, Philadelphia, Portland [ME], and Washington, DC). Diverted OxyContin® dealers also sell cocaine in Baltimore, and marijuana and methamphetamine in Billings.

Do diverted OxyContin® sellers use the drug? According to seven of eight law enforcement respondents (in Birmingham, Honolulu, New Orleans, Philadelphia, Portland [ME], Sioux Falls, and Washington, DC), OxyContin® sellers are somewhat or very likely to use the drug. Three epidemiologic sources responded to the question: the Portland and Washington, DC, respondents agree with their law enforcement counterparts that OxyContin® sellers are very likely to use the drug, but the Memphis respondent cites sellers as not very likely to use the drug.

In what types of other crimes are diverted OxyContin® sellers involved? According to most law enforcement, epidemiologic, and ethnographic respondents (8 of 12), sellers of diverted OxyContin® are somewhat or very likely to be involved in other crimes, including the following: nonviolent crimes in Billings, Boston, New Orleans, Portland (ME), and Washington, DC; violent crimes in Honolulu and Portland; prostitution in Boston and Portland; and gang-related crimes in Portland, where crimes involving diverted OxyContin® have increased according to the law enforcement source. Only by respondents in Birmingham, Memphis, and Philadelphia are diverted OxyContin® sellers regarded as not involved in other crimes.

Where is diverted OxyContin® sold? *(Exhibit 8)* Diverted OxyContin® is sold in the central city and rural areas, according to most law enforcement and epidemiologic respondents. However, suburbs are the predominant sales locales in Philadelphia, and the drug is sold throughout all areas of Boston and Portland (ME). According to the law enforcement source in Washington, DC, most sales occur in the central city, but the buyers reside in the suburbs.

According to law enforcement, epidemiologic/ethnographic, and treatment respondents, diverted OxyContin® is sold most often in private residences, followed by streets and around methadone treatment clinics. The reported number of diverted OxyContin® sales settings is highest in Boston and New Orleans.

**Exhibit 8.**
**Where is diverted OxyContin® sold and abused across 17 *Pulse Check* cities?***

| | City | Streets | | Private Residences | | Public Housing | | Inside Cars | | Crack Houses | | Private Parties | | Methadone Clinics | | Nightclubs/ Bars | | Around Supermarkets | | College Campus | | Playgrounds/ Parks | | Concerts/ Raves | | Shopping Malls | | Total # Settings | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use | Sell | Use |
| Northeast | Boston, MA | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | 13 | 4 |
| | Philadelphia, PA | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | | | ✓ | | | | | | ✓ | | | | | 2 | 7 |
| | Portland, ME | | | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | | | | | | | | | | 3 | 2 |
| South | Baltimore, MD | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | | | ✓ | | | | | | | | | | | | | | 5 | 4 |
| | Birmingham, AL | | | ✓ | ✓ | | | | | | | | ✓ | | | | | | | | | | | | | | | 1 | 2 |
| | Columbia, SC | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | NR | 1 |
| | Memphis, TN | | | | ✓ | | | | | | | | | | | | | | | ✓ | | | | | | | | NR | 2 |
| | Miami, FL | | | | ✓ | | | | | | ✓ | | | | | | | | | | | | | | ✓ | | | NR | 3 |
| | New Orleans, LA | ✓ | | ✓ | | ✓ | | ✓ | | | | ✓ | | ✓ | | ✓ | | ✓ | | | | ✓ | | ✓ | | ✓ | | 11 | NR |
| | Washington, DC | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | ✓ | | | | | | | | | | | | | | 4 | 5 |
| Midwest | Detroit, MI | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | NR | 1 |
| | St. Louis, MO | | | | ✓ | | ✓ | | ✓ | | | | ✓ | | | | ✓ | | | | ✓ | | | | ✓ | | | NR | 7 |
| West | Billings, MT | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | | ✓ | | | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | ✓ | 2 | 10 |
| | Denver, CO | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | NR | 1 |
| | Honolulu, HI | ✓ | | ✓ | | ✓ | | | | | | | | ✓ | | | | | | | | | | | | | | 4 | NR |
| | Seattle, WA | | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | | | | | | | | ✓ | | | | | NR | 5 |

*Sources: Law enforcement, epidemiologic, ethnographic, and methadone and non-methadone treatment respondents*
**For sales settings seven law enforcement sources responded (in Billings, Birmingham, Boston, Honolulu, New Orleans, Philadelphia, Portland [ME], and Washington, DC) and three epidemiologic and ethnographic sources responded (in Baltimore, Boston, Portland [ME], and Washington, DC). For users settings, nine epidemiologic and ethnographic sources responded (in Baltimore, Detroit, Memphis, Miami, Philadelphia, Portland [ME], St. Louis, and Washington, DC), seven methadone treatment sources responded (in Boston, Columbia [SE], Denver, Portland [ME], St. Louis, Seattle and Washington, DC), and eight non-methadone treatment sources responded (in Billings, Birmingham, Baltimore, El Paso, Miami, Philadelphia, Portland [ME] and St. Louis).*

## OXYCONTIN®: THE ABUSERS

**How has the number of novice OxyContin® treatment clients changed?** *(Exhibit 9)* According to most (12 of 16) methadone and non-methadone treatment respondents, the number of novice users of diverted OxyContin® in treatment (defined as any drug treatment client who has recently begun using diverted OxyContin®) has increased since the last reporting period, mainly in the South. The remaining respondents reporting stable trends.

**Who abuses OxyContin® and where do they reside?** *(Exhibits 10 and 11)* This section refers to those who abuse diverted OxyContin®, not those who are prescribed the drug for a legitimate medical need. Most OxyContin® abusers are young adults (18–30 years) or adults (>30 years), according to most epidemiologic, ethnographic, and methadone and non-methadone treatment respondents. However, according to the epidemiologic and methadone treatment sources in Portland (ME) and the epidemiologic source in Miami, adolescent (13–17 years) and young adult abusers are increasing.

Males are the predominant OxyContin® abusers, according to most (5 of 9) epidemiologic and ethnographic respondents (in Baltimore, Detroit, Memphis, Miami, and Philadelphia). However, males and females are equally likely to abuse the drug in Birmingham, Columbia (SC), Portland (ME), and Washington, DC. Treatment respondents agree that males are the predominant users or that they are evenly split between the genders. Females predominate, however, in treatment programs in Baltimore, St. Louis, and two Western cities (Billings and Denver).

Whites are the predominant OxyContin® abusers and are overrepresented compared with the general population, according to nearly all epidemiologic and ethnographic respondents. Blacks, however, are the predominant abusers and overrepresented in Baltimore and Washington, DC. Most treatment respondents agree that Whites predominate as OxyContin® abusers. Additionally,

**Exhibit 9.**
**How has the number of novice OxyContin® treatment clients changed (fall 2000 vs spring 2001)?**


*[M]Methodone treatment respondents*
*[N]Non-methadone treatment respondents*
*Notes: Billings has two non-methadone treatment sources.*

Whites from rural areas are increasingly abusing the drug, according to the epidemiologic sources in Birmingham and Washington, DC.

Most OxyContin® abusers are of low or middle SES, according to nearly all epidemiologic, ethnographic, and methadone and non-methadone treatment respondents. Additionally, according to treatment respondents, OxyContin® abusers in the Northeast are more likely to be of low SES than those in other regions.

The locations of OxyContin® abusers' residences vary by city, according to epidemiologic and ethnographic respondents: in Baltimore, Philadelphia, and Washington, DC, they reside in central city areas; in Detroit, Birmingham, and Memphis, they reside in rural areas and the suburbs; and in Columbia (SC) and Miami, they reside in the suburbs. Most treatment respondents concur with their epidemiologic counterparts.

### OxyContin® users in treatment: Referral sources, education, and employment

The most common referral sources for OxyContin® treatment clients, according to methadone and non-methadone treatment respondents, are individual referrals (in Baltimore, Birmingham, Boston, Columbia [SC], Denver, Miami, Philadelphia, Portland [ME], St. Louis, Seattle, and Washington, DC), followed by courts or the criminal justice system (in Philadelphia, Portland [ME], and St. Louis) and health care providers (in Billings, El Paso, and Portland). According to the Denver methadone source, doctors are a common referral source: doctors who have been prescribing OxyContin® to their patients for pain refer them to treatment when they believe their patients may have an addiction.

Nearly all (14 of 17) treatment respondents report that most OxyContin® abusers have a high school education. Only the methadone source in Seattle and the methadone and non-methadone sources in Philadelphia report that most OxyContin® users have less than a high school education. The employment status of OxyContin® abusers varies widely according to treatment respondents, with most reporting full-time employment or unemployment. Additionally, the non-methadone source in El Paso reports that most are retired or disabled, and the methadone treatment source in Boston reports that most are unemployed due to chronic pain.

### OxyContin® abuse among health care professional and adolescents...

Only 5 of 23 epidemiologic, ethnographic, and methadone and non-methadone treatment respondents (in Baltimore, Billings, Portland (ME), St. Louis, and Seattle) report health care professionals as involved in OxyContin® abuse.

Seven respondents in six cities report OxyContin® abuse among opioid-naïve adolescents (in Billings, Boston, Detroit, Miami, Portland (ME), and St. Louis).

### Where and in what contexts do OxyContin® abusers tend to use the drug?

*(Exhibit 8)* Most OxyContin® abusers use the drug indoors and in private, according to all (eight of eight) epidemiologic respondents (in Baltimore, Birmingham, Detroit, Memphis, Miami, Philadelphia, Portland (ME), and Washington, DC). Treatment respondents agree that diverted OxyContin® is primarily used indoors and in private, but the Birmingham non-methadone source cites both indoor and outdoor use because, "you can take a pill anywhere." According to the epidemiologic sources in Memphis, Philadelphia, and Washington, DC, they primarily use the drug in groups or among friends, but in Baltimore, Miami, and Portland (ME), most use the drug alone. By contrast, most (8 of 12) treatment respondents (in Billings, Birmingham, Columbia (SC), Denver, Portland (ME), St. Louis, and Washington, DC) report that most OxyContin® abusers take the drug alone.

The most frequently mentioned settings for abuse of diverted OxyContin®, according to epidemiologic, ethnographic, and non-methadone and methadone treatment respondents, are private residences, followed by public housing developments, inside cars, and private parties. Other common settings include streets (in Baltimore, Billings, Philadelphia, and Washington, DC), nightclubs and bars (in Billings, Boston, Philadelphia, and St. Louis), and concerts and raves (in Boston, Miami, and St. Louis).

**How is OxyContin® taken, and what other drugs do OxyContin® users take?** Unlike those with a legitimate medical need for OxyContin® who injest the pill orally by swallowing it whole, OxyContin® abusers seek to deactivate the time-release formula by injecting, chewing, or snorting the crushed pill or tablet to achieve rapid release and absorption of oxycodone, according to epidemiologic and ethnographic respondents. Injection (by crushing the pill, dissolving it in water or cooking it, and typically injecting it through cotton balls or cotton pads—hence, its street name "oxycotton") is reported in seven cities (Baltimore, Birmingham, Detroit, Portland [ME], Philadelphia, St. Louis, and Washington, DC). The diverted drug is taken orally (often chewed) in three cities (Memphis, Miami, and Philadelphia), and it is crushed and snorted in Columbia (SC) and Detroit. Unlike epidemiologic and ethnographic respondents, treatment sources overwhelmingly (16 of 20 respondents) cite oral ingestion as the predominant mode of OxyContin® administration by hardcore drug users. Injecting the drug is only mentioned by the Billings non-methadone treatment source, and snorting crushed pills is mentioned only by three sources: the methadone treatment source in Boston and the methadone and non-methadone sources in Portland (ME). According to the epidemiologic source in Washington, DC, oral ingestion of the drug is increasing.

Few epidemiologic, ethnographic, or treatment respondents report other drugs used in combination with diverted OxyContin®, and most drugs mentioned are other prescription drugs that have been diverted. For example, benzodiazepines are taken in combination with OxyContin® in Baltimore, Boston, Columbia (SC), Philadelphia, and Seattle. Other diverted prescription opiates are combined with OxyContin® in Billings (Percocet®, meperidine [Demerol®] or morphine), Philadelphia® (Percocet®), and Miami (hydrocodone [Vicodin® or Lorcet®], or carisoprodol [Soma®]). Heroin is used with diverted OxyContin® in Boston, Billings, and St. Louis, and crack in Billings and Philadelphia. In Boston, diverted OxyContin® is sometimes used with ecstasy to assuage the effects of ecstasy.

Several sources report that OxyContin® abusers have previously used drugs other than opiates. According to the law enforcement source in Billings, methamphetamine users who are unable to obtain methamphetamine or are looking for a more sustained high may begin using diverted OxyContin®, and according to the Boston methadone treatment source, OxyContin® users tend to have already experimented with marijuana and sometimes cocaine.

**How often do OxyContin® abusers use the drug?** Most OxyContin® abusers take the drug at least daily, according to most (11 of 15) treatment respondents (in Birmingham, Boston, Columbia [SC], Denver, Philadelphia, Portland [ME], St. Louis, and Washington, DC). The methadone treatment sources in Boston and Philadelphia report that OxyContin® abusers begin using the drug occasionally or on weekends, but they often quickly progress to daily use.

**How is heroin related to OxyContin® abuse?**

According to many *Pulse Check* sources, heroin users often abuse diverted OxyContin®, mostly as a heroin substitute. Seven respondents (the law enforcement sources in New Orleans and Philadelphia; the epidemiologic source in Miami, the methadone treatment sources in Philadelphia and Seattle; and the non-methadone treatment sources in Birmingham and St. Louis) report that heroin users often replace heroin with diverted OxyContin®, especially when heroin is scarce. Four respondents (the Portland (ME) law enforcement source, the Boston methadone treatment source, and the Billings and St. Louis non-methadone treatment sources) state that diverted OxyContin® may be used in combination with heroin to enhance the effects of heroin. And the methadone treatment sources in Columbia (SC) and Washington, DC, report that heroin users often take illegally obtained OxyContin® to "tide them over" until their next dose of heroin or methadone.

By contrast, in Chicago, the diversion and abuse of other prescription opiates abuse continues to be low because heroin is readily available and less expensive there. Sources also point out that many OxyContin® abusers use the drug exclusively. For example, in Birmingham, most OxyContin® abusers use the drug rather than heroin or other diverted prescription drugs because they believe it is more potent. And the law enforcement source in Boston reports that most Oxy-Contin® abusers do not use heroin, but that they may start to use heroin if they are unable get their OxyContin® "fix."

**Exhibit 10.**
**Who abuses diverted OxyContin®, according to epidemiologic and ethnographic respondents?**

| | City | Age | Gender | Race/Ethnicity; representation compared with the general population | Socioeconomic Status | Residence |
|---|---|---|---|---|---|---|
| Northeast | Philadelphia, PA | Young adults (18–30) and adults (>30) | Male | White; underrepresented | Low | Central city |
| | Portland, ME | Young adults | Split evenly | White; equal | Low | All |
| South | Baltimore, MD | Adults | Male | Black; overrepresented | Low | Central city |
| | Birmingham, AL | Adolescents (13–17) | Split evenly | White; overrepresented | Low and middle | Suburbs and rural areas |
| | Columbia, SC | Young adults | Split evenly | White; equal | Middle | Suburbs |
| | Memphis, TN | Young adults | Male | White; overrepresented | Middle | Suburbs and rural areas |
| | Miami, FL | Adults | Male | White; overrepresented | Low | Suburbs |
| | Washington, DC | Adults | Split evenly | Black; overrepresented | Low | Central city |
| Midwest | Detroit, MI | Young adults and adults | Male | White; overrepresented | Middle and high | Suburbs and rural areas |

**Exhibit 11.**
**Who abuses diverted OxyContin®, according to methadone and non-methadone treatment respondents?**

| | City | Treatment source | Age | Gender | Race/Ethnicity; representation compared with the general population | Socioeconomic Status | Residence |
|---|---|---|---|---|---|---|---|
| Northeast | Boston, MA | Methadone | Adults (>30) | Split evenly | White; equal | Low | Suburbs |
| | Philadelphia, PA | Methadone | Young adults (18–30) | Split evenly | White; NR | Low | Central city |
| | | Non-methadone | Young adults | Split evenly | White, Black, Hispanic; equal | Low | Central city |
| | Portland, ME | Methadone | Young adults | Split evenly | White; NR | Low and middle | Central city |
| | | Non-methadone | Adults | Male | White; NR | Low | Rural |
| | Baltimore, MD | Non-methadone | Young adults | Female | White; underrepresented | High | Central city |
| South | Birmingham, AL | Methadone | Young adults | Male | White; equal | Middle | Suburbs |
| | | Non-methadone | Young adults | Split evenly | White; equal | Low and middle | Suburbs |
| | Columbia, SC | Methadone | Young adults | Male | White; equal | Middle | Rural |
| | El Paso, TX | Non-methadone | Adults | Male | White, Black, Hispanic; equal | All | Central city and suburbs |
| | Miami, FL | Non-methadone | Adults | Split evenly | White; overrepresented | Middle | Suburbs |
| | New Orleans, LA | Non-methadone | Adults | Male | White; NR | Middle | Central city |
| | Washington, DC | Methadone | Adults | Male | White, Black; NR | Low | Central city |
| Midwest | St. Louis, MO | Methadone | Young adults | Split evenly | Multi-racial; NR | Middle | Suburbs and central city |
| | | Non-methadone | Young adults | Female | White; NR | Middle | Suburbs |
| West | Billings, MT | Non-methadone | Young adults | Female | White; NR | Low | Suburbs |
| | Denver, CO | Methadone | Adults | Female | White; NR | Middle | Suburbs |
| | Honolulu, HI | Non-methadone | Adults | Male | Asian/Pacific Islander; NR | Middle | Suburbs |
| | Seattle, WA | Methadone | Adults | Split evenly | White; equal | Low | Central |

## APPENDIX 1: METHODOLOGY

### How were the sites selected?

*(See map in the Introduction)* A total of 21 sites were studied for this issue of *Pulse Check*, including a new site not studied in the last (Mid-Year 2000) issue: Baltimore, MD. Baltimore was included at the request of the Office of National Drug Control Policy (ONDCP) because of concerns about its unique problems involving heroin and cocaine. We selected the other 20 sites using Census Bureau regions and divisions with a goal of achieving geographic and demographic diversity. In addition, we made an effort to select sites in areas with special drug abuse problems of national concern. More specifically, we applied the following methodology in selecting sites.

We purposely selected the most populous States in the four census regions: New York in Region I (Northeast Region); Texas in Region II (South Region); Illinois in Region III (Midwest Region); and California in Region IV (West Region). In three of these States, we selected the most populous metropolitan areas: New York City, Chicago, and Los Angeles. In Texas, however, we selected El Paso—a known high trafficking area with particularly high levels of unemployment, population growth, and poverty—because of its proximity to the United States border with Mexico.

We included four rural States, one per census region. (Rural States are defined by the Census Bureau as those in which 50 percent or more of the State's population reside in census-designated rural areas.) The four rural sites selected are as follows:

- Region I (Northeast): Portland, ME—Of the three rural States in the Northeast Region (including New Hampshire and Vermont), Maine has the only Atlantic coastline and shares the longest border with Canada. It also includes an ONDCP-designated High Intensity Drug Trafficking Area (HIDTA). Portland is Maine's most populous metropolitan area.

- Region II (South): Columbia, SC—The three other rural States in the South census region are Kentucky, Mississippi, and West Virginia. However, South Carolina's location along a major drug trafficking corridor makes that State a strategic choice. Recent cocaine seizures in Columbia further highlight its strategic importance.

- Region III (Midwest): Sioux Falls, SD—Sioux Falls is the most populous metropolitan area within the Midwest Region's two rural States (North Dakota and South Dakota).

- Region IV (West): Billings, MT—Montana is the only census-designated rural State in the West Region, and Billings is its most populous metropolitan area.

The remaining 12 sites were selected to ensure that the entire list included at least 2 sites from each of the 9 Census Bureau divisions (East North Central, Mountain, Middle Atlantic, New England, Pacific, South Atlantic, South East Central, South West Central, and West North Central). Additional selection criteria included population density, representation of racial/ethnic minorities, and emphasis on high drug trafficking areas.

Applying these criteria resulted in the final selection of the following 21 *Pulse Check* sites:

**Baltimore, MD**
**Billings, MT**
**Birmingham, AL**
**Boston, MA**
**Chicago, IL**
**Columbia, SC**
**Denver, CO**
**Detroit, MI**
**El Paso, TX**
**Honolulu, HI**
**Los Angeles, CA**
**Miami, FL**
**Memphis, TN**
**New Orleans, LA**
**New York City, NY**
**Philadelphia, PA**
**Portland, ME**
**St. Louis, MO**
**Seattle, WA**
**Sioux Falls, SD**
**Washington, DC**

### How do the 21 sites vary demographically?

Appendix 2 highlights the demographic diversity of these 21 sites. For example, their population density per square kilometer ranges from a sparse 18.6 in Billings, MT, to a crowded 2,931.6 in New York City. Their unemployment rates range from a 1.7 low in Sioux Falls, SD, to a 9.4 high in El Paso, TX. The racial/ethnic breakdowns in the 21 sites further exemplify their diversity: White representation ranges from 30.9 percent in Honolulu, HI, to 97.8 percent in Portland, ME; Black representation ranges from 0.5 percent in Billings, MT, to 42.4 percent in Memphis, TN; and Hispanic representation ranges from less than 1 percent in Birmingham, AL, and Portland, ME, to 75.4 percent in El Paso, TX.

What other data are available at the 21 selected sites? Information from other national-level data sources will be useful for framing, comparing, corroborating, enhancing, or explaining the information obtained for *Pulse Check*. The following data sources, listed in Appendix 3, are available in nearly every site: ONDCP's past *Pulse Check* reports; the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG); the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN); and the National Institute of Justice (NIJ) Arrestee Drug Abuse Monitoring (ADAM) program.

Who are the *Pulse Check* sources, and how were they selected? Consistent with previous issues, the information sources for *Pulse Check* were telephone discussions with 4 knowledgeable individuals in each of the 21 sites: 1 ethnographer or epidemiologist, 1 law enforcement official, and 2 treatment providers. Excluding the new Baltimore recruits, the vast majority of the 42 epidemiologists, ethnographers, and law enforcement sources who reported for this issue of *Pulse Check* were the same, or associated with the same agencies, as those who reported for the previous issue. Ethnographers and epidemiologists were recruited based on several possible criteria: past participation in the *Pulse Check* program; membership in NIDA's CEWG; research activities in local universities; or service in local community programs. We recruited law enforcement officials by contacting local police department narcotic units, Drug Enforcement Administration (DEA) local offices, and HIDTA directors.

To identify treatment sources for the previous (Mid-Year 2000) issue of *Pulse Check*, we randomly selected providers from the 1998 Uniform Facility Data Set (UFDS), a listing of Federal, State, local, and private facilities that offer drug abuse and alcoholism treatment services. For this purpose, we excluded facilities that reported more than 50 percent of their clientele as having a primary alcohol abuse problem, served a caseload of fewer than 100 clients, or provided only prevention or detox services. We then divided the remaining facilities into two groups—methadone and non-methadone treatment facilities—in order to capture two client populations whose demographic characteristics and use patterns often differ widely. We selected one from each of these two categories of programs for each of the 20 selected sites. Because Billings, MT, and Sioux Falls, SD, have no UFDS-listed methadone treatment facilities, we selected two non-methadone facilities in those sites.

For this issue of *Pulse Check*, in order to preserve continuity, we retained all available treatment sources who reported for the last issue. Additionally, to ensure regular reporting for the future, any treatment provider who was unavailable to participate was replaced via purposeful, rather than random, selection based on consultation with experts in the field. Altogether, we recruited 43 treatment sources: 20 methadone providers (2 from Boston, and 1 from each of the other *Pulse Check* sites except for Billings and Sioux Falls), and 23 non-methadone providers (1 from each *Pulse Check* site plus extra sources from Billings and Sioux Falls to compensate for their lack of methadone representation).

Thus, a total of 85 sources were identified and recruited, and we successfully obtained information for this *Pulse Check* issue from 83 of them: a response rate of 98 percent. The nonresponding participants were the methadone treatment providers from Baltimore and Memphis. A full list of responding sources appears in Appendix 4.

What kind of data were collected, and how? For each of the 83 responding sources, we conducted a single telephone discussion lasting about 1 hour. We asked sources to explore with us their perceptions of the change in the drug abuse situation between spring 2000 and fall 2001. We discussed a broad range topic areas with these individuals, as delineated in Appendix 5. Not surprisingly, ethnographic and epidemiologic sources seemed to be very knowledgeable about users and patterns of use; they were somewhat knowledgeable about drug availability; and they were less informed about sellers, distribution, and trafficking patterns. Treatment providers had a similar range of knowledge, but they generally focused on the specific populations targeted by their programs. Some providers, however, were able to provide a broader perspective about the communities extending beyond their individual programs. Among the three *Pulse Check* source types, law enforcement officials appeared to be most knowledgeable about drug availability, trafficking patterns, seller characteristics, sales practices, and other associated activities; they were, understandably, less knowledgeable about user groups and characteristics.

## APPENDIX 2: POPULATION DEMOGRAPHICS IN THE 21 *PULSE CHECK* SITES

| | *Pulse Check* Site | MSA Size* (S, M, L, X) | Race Percent[a] White | Black | American Indian Eskimo Aleut. | Asian and Pacific Islander | Percent Hispanic[a] | Violent Crime/ 100,000 Population[b] | Percent Persons Under18 Below Poverty Level[c] | Unemployment Rate | Population Density/ Square KM[a] | Percent Population Change[d] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Northeast | Boston, MA[1] | X | 89.9 | 6.0 | .2 | 3.9 | 5.7 | 505 | 15.2 | 3.1 | 353.3 | 3.8 |
| | New York City, NY | X | 61.3 | 28.9 | .4 | 9.3 | 25.6 | 1,037 | 32.9 | 6.2 | 2,931.6 | 1.9 |
| | Philadelphia, PA-NJ | L | 76.5 | 20.1 | .2 | 3.2 | 4.7 | 667 | 17.1 | 4.1 | 495.7 | .6 |
| | Portland, ME | S | 97.8 | .8 | .3 | 2.6 | 2.0 | 730 | 16.6 | 4.0 | 368.7 | 4.6 |
| South | Baltimore, MD | L | 69.1 | 28.0 | .3 | .6 | .8 | 581 | 19.4 | 3.1 | 110.9 | 8.9 |
| | Birmingham, AL | M | 70.4 | 28.9 | .2 | .6 | .8 | 581 | 19.4 | 3.1 | 110.9 | 8.9 |
| | Columbia, SC | M | 68.7 | 29.6 | .2 | 1.5 | 2.1 | 868 | 19.2 | 2.5 | 136.8 | 13.8 |
| | El Paso, TX | M | 94.5 | 3.4 | .5 | 1.5 | 75.4 | 668 | 38.6 | 9.4 | 267.5 | 18.6 |
| | Memphis, TN | L | 56.3 | 42.4 | .2 | 1.2 | 1.3 | 1,081 | 21.4 | 3.6 | 141.9 | 9.7 |
| | Miami, FL | L | 77.6 | 20.4 | .3 | 1.8 | 57.4 | 1,532 | 29.6 | 5.8 | 432.0 | 12.3 |
| | New Orleans, LA | L | 62.6 | 34.9 | .3 | 2.2 | 5.2 | 918 | 26.4 | 4.4 | 148.2 | 1.6 |
| | Washington, DC[2] | L | 67.7 | 25.3 | .3 | 6.7 | 7.6 | 537 | 12.8 | 2.6 | 281.1 | 12.2 |
| Midwest | Chicago, IL | X | 75.8 | 19.3 | .2 | 4.6 | 14.8 | NA | 17.2 | 4.1 | 610.5 | 8.1 |
| | Detroit, MI | L | 74.9 | 22.6 | .4 | 2.0 | 2.5 | 870 | 19.1 | 3.5 | 433.3 | 4.9 |
| | Sioux Falls, SD | S | 96.9 | 0.8 | 1.5 | 0.8 | 0.9 | 252 | 11.4 | 1.7 | 45.8 | 18.1 |
| | St. Louis, MO-IL | L | 80.8 | 17.6 | .2 | 1.3 | 1.5 | NA | 16.4 | 3.7 | 155.2 | 3.1 |
| West | Billings, MT | S | 95.5 | .5 | 3.3 | .6 | 3.3 | 187 | 16.8 | 4.0 | 18.6 | 12.2 |
| | Denver, CO | L | 89.8 | 6.2 | .8 | 3.1 | 14.9 | 385 | 13.4 | 2.4 | 203.2 | 21.9 |
| | Honolulu, HI | M | 30.9 | 3.6 | .5 | 65.0 | 7.4 | 268 | 14.8 | 4.9 | 556.4 | 3.4 |
| | Los Angeles, CA[3] | X | 74.8 | 11.2 | .6 | 13.4 | 44.4 | 1,027 | 30.5 | 5.9 | 887.3 | 5.3 |
| | Seattle, WA[4] | L | 84.7 | 4.7 | 1.3 | 9.3 | 4.3 | 419 | 11.7 | 3.4 | 203.7 | 14.8 |

**Small = <300,000 persons; Medium = 300,000–1 million persons; Large = 1 million–5 million persons; Extra Large = >5 million persons*

*[1]Includes Worcester, Lawrence, Lowell, Brockton MA-NH*

*[2]Includes Washington, DC-MD-VA-WVA*

*[3]Includes Los Angeles-Long Beach*

*[4]Includes Seattle, Bellevue-Everett, WA*

*[a]1999*

*[b]1998*

*[c]1997*

*[d]1990–1999*

*Note: Shaded boxes indicate that selected city is in a rural State.*

*SOURCE: 2001 County and City Extra: Annual Metro, City, and County Data Book, Tenth Edition. Eds: Gaquin, D.A., and Littman, M.S. Washington, DC: Bernan Press*

## APPENDIX 3: NATIONAL-LEVEL DATA SOURCES AVAILABLE IN THE 21 *PULSE CHECK* SITES

| | *Pulse Check* Site | HIDTA[1] State | CEWG[2] | DAWN[3] | ADAM[4] |
|---|---|---|---|---|---|
| Northeast | Boston, MA | ✓ | ✓ | ✓ | |
| | New York, NY | ✓ | ✓ | ✓ | ✓ |
| | Philadelphia, PA | | ✓ | ✓ | ✓ |
| | Portland, ME | ✓ | | | |
| South | Baltimore, MD | ✓ | ✓ | ✓ | |
| | Birmingham, AL | ✓ | | | ✓ |
| | Columbia, SC | | | | |
| | El Paso, TX | ✓ | ✓ | | |
| | Memphis, TN | ✓ | | | |
| | Miami, FL | ✓ | ✓ | ✓ | ✓ |
| | New Orleans, LA | ✓ | ✓ | ✓ | ✓ |
| | Washington, DC | ✓ | ✓ | ✓ | ✓ |
| Midwest | Chicago, IL | ✓ | ✓ | ✓ | ✓ |
| | Detroit, MI | ✓ | ✓ | ✓ | ✓ |
| | Sioux Falls, SD | ✓ | | | |
| | St. Louis, MO | ✓ | ✓ | ✓ | |
| West | Billings, MT | | | | |
| | Denver, CO | ✓ | ✓ | ✓ | ✓ |
| | Los Angeles, CA | ✓ | ✓ | ✓ | ✓ |
| | Honolulu, HI | ✓ | ✓ | | |
| | Seattle, WA | ✓ | ✓ | ✓ | ✓ |

*[1]High Intensity Drug Trafficking Area of the Drug Enforcement Administration (DEA)*

*[2]Community Epidemiology Work Group of the National Institute on Drug Abuse (NIDA)*

*[3]Drug Abuse Warning Network of the Substance Abuse and Mental Health Services Administration (SAMHSA)*

*[4]Arrestee Drug Abuse Monitoring program of the National Institute of Justice (NIJ)*

*Note: Shaded boxes indicate that selected citiy is in a rural State.*

| *Pulse Check* Site | Epidemiology/Ethnography | Law Enforcement |
|---|---|---|
| Baltimore, MD | **James Peterson**<br>Johns Hopkins University<br>School of Public Health | **Richard Hite**<br>Baltimore Police Department |
| Billings, MT | **Ernesto Randolfi, Ph.D.**<br>Montana State University at Billings<br>Department of Health and Physical Education | **Scott Forshee**<br>City/County Special Investigations Unit |
| Birmingham, AL | **Foster Cook**<br>University of Alabama | **Sergeant T.E. Thrash**<br>Birmingham Police Department Vice and Narcotics Division |
| Boston, MA | **George Arlos**<br>Substance Abuse Treatment<br>and Prevention Services | **Lieutenant Francis W. Armstrong, Jr.**<br>Boston Police Department<br>Drug Control Division |
| Chicago, IL | **Larry Ouellet, Ph.D.**<br>University of Illinois at Chicago<br>School of Public Health | Chicago Police Department<br>Organized Crime Division, Narcotic<br>and Gang Investigations Section |
| Columbia, SC | **Dennis Nalty, Ph.D.**<br>Department of Alcohol and<br>Other Drug Abuse Services | Columbia Police Department<br>Organized Crime and Narcotics Unit |
| Denver, CO | **Bruce D. Mendelson, M.P.A.**<br>State Treatment Needs Assessment Contract<br>Colorado Department of Human Services<br>Alcohol and Drug Abuse Division | **Curt Williams, B.S.**<br>Denver Police Department |
| Detroit, MI | **Richard F. Calkins**<br>Michigan Department of Community Health<br>Division of Substance Abuse Quality and Planning | Southeast Michigan HIDTA |
| El Paso, TX | **Tessa Hill, M.A.**<br>Aliviane, Inc. | **Jeff Cole**<br>El Paso Police Department, Narcotics Unit |
| Honolulu, HI | **D. William Wood, Ph.D., M.P.H.**<br>University of Hawaii<br>Department of Sociology | **Lieutenant Mike Moses**<br>Narcotics, Vice Division<br>Honolulu Police Department |
| Los Angeles, CA | **Richard Rawson, Ph.D.**<br>University of California, Los Angeles<br>Integrated Substance Abuse Programs (ISAP) | Criminal Intelligence Group<br>Los Angeles Police Department |
| Memphis, TN | **Randolph Dupont, Ph.D.**<br>Department of Psychiatry<br>University of Tennessee | **Fred Romero**<br>Memphis Police Department<br>Vice Narcotics Unit |
| Miami, FL | **James N. Hall**<br>Up Front Drug Information Center | **Prefers anonymity** |
| New Orleans, LA | **Gail Thornton-Collins**<br>New Orleans Health Department | **Lieutenant Commander Bruce Adams**<br>Narcotics Major Case Section<br>New Orleans Police Department |
| New York, NY | **John A. Galea, M.A.**<br>New York State Office of Alcoholism<br>and Substance Abuse Services<br>Street Studies Unit | Drug Enforcement Administration<br>New York Division |
| Philadelphia, PA | **Samuel J. Cutler**<br>Philadelphia Behavioral Health System<br>Coordinating Office for Drug<br>and Alcohol Abuse Programs | Drug Enforcement Administration<br>Philadelphia Field Division<br>Divisional Intelligence Group |
| Portland, ME | **Nate Nickerson, R.N., M.S.N.**<br>Public Health Division,<br>Department of Health and Human Services<br>City of Portland | **George Connick**<br>Augusta Field Office/ Maine Drug Enforcement Agency |
| Seattle, WA | **Thomas R. Jackson, M.S.W.**<br>Evergreen Treatment Services | **Steve Freng**<br>High Intensity Drug Trafficking Area |
| Sioux Falls, SD | Prairie View Prevention Services | **Jerry Mundt & Lieutenant Doug Barthell**<br>Sioux Falls Police Department<br>Narcotics Division |
| St. Louis, MO | **James M. Topolski, Ph.D.**<br>Missouri Institute of Mental Health | **Detective Leo Rice**<br>St. Louis Police Department<br>Narcotics Division |
| Washington, DC | **Alfred Pach, Ph.D., M.P.H.**<br>National Opinion Research Center | **Sergeant John Brennan**<br>Washington, D.C. Police Department<br>Major Narcotics |

| *Pulse Check* Site | Non-Methadone Treatment | Methadone Treatment |
|---|---|---|
| Baltimore, MD | **Ruth Daiker**<br>Jones Falls Community Corporation | **Nonrespondent** |
| Billings , MT | **Mona Sumner**<br>Rimrock Foundation | **Illegal in the State of Montana** |
| | **Deena Vandersloot**<br>South Central Mental Health Center<br>Journey Recovery Program | |
| Birmingham, AL | **Eleanor D. Powers**<br>Program prefers anonymity | **Bill Garrett, M.P.H.**<br>University of Alabama<br>Birmingham Substance Abuse Program |
| Boston, MA | **Jim Sweeney**<br>Gavin House | **Joanne Swindell**<br>CAB Health and Recovery Services<br>**Patrick Griswold**<br>NCIA |
| Chicago, IL | **Del Larkin**<br>Association House of Chicago | **Terrie Matthes**<br>Cornell Interventions |
| Columbia, SD | **Bryan Fox**<br>Palmetta Baptist Medical Center | **Jim Van Frank**<br>Columbia Metro Treatment Center |
| Denver, CO | **Tim McCarthy**<br>Arapahoe House | **Pamela J. Manuele, RN, BSN, ANPC, CCJS**<br>Comprehensive Addiction Treatment Services |
| Detroit, MI | Renaissance West Community Health Services | **Octavius Sapp, C.A.C.**<br>City of Detroit, Department of Human Services<br>Drug Treatment |
| El Paso, TX | **Armando Salas**<br>Aliviane Men's Residential Facility | **Julie Renteria, L.V.N.**<br>El Paso Methadone Maintenance<br>and Detox Treatment Center |
| Honolulu, HI | **Andy Anderson**<br>Hina Mauka Recover Center | **Lisa Cook**<br>Drug Addiction Services of Hawaii |
| Los Angeles, CA | **Mari Radzik, Ph.D.**<br>Substance Abuse Treatment Program<br>Division of Adolescent Medicine<br>Children's Hospital of Los Angeles | **Wynnell Domeniguez**<br>West Los Angeles Treatment Program |
| Memphis, TN | **Sharon Davis**<br>Frayser Family Counseling Center | **Nonrespondent** |
| Miami, FL | **Michael Miller**<br>The Village South, Inc.<br>Addiction Treatment Center | **Prefers anonymity** |
| New Orleans, LA | **Eleanor Glapion**<br>New Orleans Substance Abuse Clinic | DRD Clinic |
| Bronx, NY | Narco Freedom | **Eugenia Curet, Ph. D.**<br>Adult Service Clinic<br>The New York Presbyterian Hospital |
| Philadelphia, PA | **C. Joseph Schultz, M.Ed.**<br>Northeast Treatment | **Peter A. Demaria, Jr., M.D., FASAM**<br>Department of Psychiatry and Human Behavior<br>Jefferson Medical College |
| Portland, ME | **Stephen Leary**<br>Milestone Foundation, Inc. | Discovery House Maine |
| Seattle, WA | **Ramona Graham**<br>Center for Human Services | **Victoria Evans**<br>Therapeutic Health Services |
| Sioux Falls, SD | **Robin Erz, CCDCIII**<br>Turning Point Alcohol and Drug Center<br><br>Keystone Treatment Center | **Illegal in the State on South Dakota** |
| St. Louis, Missouri | **Mike Morrison**<br>Bridgeway Counseling | **Chris Johnson**<br>DART |
| Washington, D.C. | **Prefers anonymity** | **LaTonya Sullivan**<br>Umoja Treatment Center |

## APPENDIX 5: DISCUSSION AREAS BY SOURCE TYPE*

| Topic | L | E | M | N |
|---|---|---|---|---|
| **SNAPSHOT** | | | | |
| How serious is the current illegal drug problem in your community? | ✓ | ✓ | ✓ | ✓ |
| How has the illegal drug problem changed in your community? | ✓ | ✓ | ✓ | ✓ |
| **THE PERCEPTION** | | | | |
| What is the most commonly abused drug in your community during the current reporting period? Second most commonly abused drug? What drug is related to the most serious consequences? Second most serious consequences? Is any new problem drug appearing in your community? | ✓ | ✓ | ✓ | ✓ |
| What was the most commonly abused drug in you community during the last reporting period? Second most commonly abused drug in your community? What drug was related to the most serious consequences last reporting period? Second most serious consequences? | ✓ | ✓ | ✓ | ✓ |
| **THE DRUG**** | | | | |
| How available is the drug in your community (for each drug, asks about various forms)? | ✓ | ✓ | | |
| How has availability changed? | ✓ | ✓ | | |
| What are the most common and second most common units of sale and corresponding standard units of the drug? | ✓ | ✓ | ✓ *(special section only)* | ✓ *(special section only)* |
| What is the purity range for the drug during the current reporting period? During the last reporting period? | ✓ | ✓ | | |
| What is the price range during the current reporting period? During the last reporting period? | ✓ | ✓ | | |
| What is the source for your price and purity information? | ✓ | ✓ | | |
| Why have price and purity changed or why have they remained stable? | ✓ | ✓ | | |
| What are the street names, and are any of these new this reporting period? | ✓ | ✓ | ✓ | ✓ |
| What types of packaging are used, and are any of these new this reporting period? | ✓ | ✓ | | |
| Are labels or brand names used? If yes, please list and indicate if any are new this reporting period. | ✓ | ✓ | | |
| Are there any adulterants? If yes, please list and indicate if any are new this reporting period. | ✓ | ✓ | ✓ | ✓ |
| Have there been any changes in street names, packaging, labels, or adulterants since the last reporting period? If yes, please describe. | ✓ | ✓ | | |
| **THE SALE**** | | | | |
| How is the drug manufactured, processed, or grown? | ✓ | ✓ | | |
| What is the source country or point of origin? | ✓ | ✓ | | |
| What are the transshipment cities? | ✓ | ✓ | | |
| What is the point of entry? | ✓ | ✓ | | |
| What is the final destination city or region? | ✓ | ✓ | | |
| Have there been any changes in manufacturing process or trafficking since the last reporting period? If yes, please describe. | ✓ | ✓ | | |
| What is the predominant affiliation of local, street-level sellers? | ✓ | ✓ | | |
| How likely are sellers to use their own drugs? | ✓ | ✓ | | |
| How involved in other crimes are sellers? | ✓ | ✓ | | |
| In what type of other crimes are sellers involved? | ✓ | ✓ | | |
| Have there been any changes in seller characteristics since the last reporting period? If yes, please describe. | ✓ | ✓ | | |
| Are there any new sellers groups this reporting period? If yes, please describe. | ✓ | ✓ | | |
| What is the geographical area where most street-level sales of the drug occur? | ✓ | ✓ | | |
| Is the drug sold mostly indoors, outdoors, or evenly split between both? | ✓ | ✓ | | |
| In what settings is the drug sold? | ✓ | ✓ | | |
| How is the drug sold? | ✓ | ✓ | | |
| Are other drugs sold by this type of dealer? If yes, please list the drugs. | ✓ | ✓ | | |
| Have any of the drugs sold with this drug changed since the last reporting period? If yes, please describe. | ✓ | ✓ | | |
| What are any other distinctive features of the drug scene in your area? | ✓ | ✓ | | |
| Have any of the drug scene characteristics changed since the last reporting period? If yes, please describe. | ✓ | ✓ | | |

| THE USERS: Predominant characteristics** | L | E | M | N |
|---|---|---|---|---|
| What is the predominant age range of the drug users? | | ✓ | ✓ | ✓ |
| What is the predominant gender? | | ✓ | ✓ | ✓ |
| What is the predominant racial/ethnic group? Is this group underrepresented, overrepresented, or about equal compared with the general population in your area? | | ✓ | ✓ | ✓ |
| What is the predominant socioeconomic position? | | ✓ | ✓ | ✓ |
| What is the most common geographical residence? | | ✓ | ✓ | ✓ |
| What is the predominant route of administration? | | ✓ | ✓ | ✓ |
| What are the drugs commonly taken in combination with this drug, including any street names for the combination or practice? | | ✓ | ✓ | ✓ |
| Is the drug used mostly indoors or outdoors? | | ✓ | ✓ | ✓ |
| Is the drug used mostly in public or in private? | | ✓ | ✓ | ✓ |
| Is the drug used mostly alone or in groups/among friends? | | ✓ | ✓ | ✓ |
| What are the common settings for the use of this drug? | | ✓ | ✓ | ✓ |
| What are the unusual settings or contexts for the use of this drug? | | ✓ | ✓ | ✓ |
| What is the most common referral source? | | | ✓ | ✓ |
| What is the predominant education level? | | | ✓ | ✓ |
| What is the most common frequency of use? | | | ✓ | ✓ |
| What is the predominant employment status? | | | ✓ | ✓ |
| **THE USERS: New or emerging users**** | | | | |
| How did the number of new or emerging users change since the last reporting period? If increased, repeat the first 12 questions under "the users: predominant characteristics" for the new/emerging user group. | | ✓ | | |
| How did the number of novice users in your program change since the last reporting period? If increased, repeat all questions under "the users: predominant characteristics" for the novice user group. | | | ✓ | ✓ |
| **METHADONE DIVERSION/TREATMENT** | | | | |
| To what extent is there a methadone diversion problem from treatment programs in your community? | ✓ | | | |
| How has the diversion problem changed since the last reporting period? | ✓ | | | |
| Is illegal methadone transported into your community from other areas? | ✓ | | | |
| Who has been selling diverted methadone? | ✓ | | | |
| How is it sold? | ✓ | | | |
| Who has been buying diverted methadone? | ✓ | | | |
| What is the availability of methadone treatment in your community? | | ✓ | | |
| How has treatment availability changed since the last reporting period? | | ✓ | | |
| What is the capacity of public methadone treatment? Private methadone treatment? | | ✓ | | |
| How has the capacity of public methadone treatment changed since the last reporting period? Private methadone treatment? | | ✓ | | |
| **COMMUNITY CONTEXTS** | | | | |
| Were there substantial changes or issues involving (treatment availability or waiting time, drug-related hospital medical emergencies, drug-related deaths, large drug seizures, targeted law enforcement policy directives or initiatives, community policing, new sentencing practices, new joint task forces, new legislation, new community education or prevention programs, new public service campaigns, drug-related news events, other)? If yes, please describe. | ✓ | ✓ | | |
| How did medical, political, criminal, or societal changes or issues (listed above) impact your community''s overall drug abuse problem? | ✓ | ✓ | | |
| Have drug-related consequences (HIV/AIDS, hepatitis C, liver cirrhosis, drug-related automobile accidents, high-risk pregnancy, drug overdoses, alcohol DTs, tuberculosis, other) increased, decreased, or remained stable since the last reporting period? If changed, explain. | | | ✓ | ✓ |
| Have any of the psychiatric comorbidity diagnoses (conduct disorder, psychosis, mood disorders, suicidal thoughts/attempts, other) increased, decreased, or remained stable as a concern among your clients since last reporting period? If changed, explain. | | | ✓ | ✓ |
| Do any potential barriers (limited slot capacity, lack of trained staff to treat comorbid clients, violent behavior among presenting clients, age restrictions, other) prevent your program from serving all individuals who seek treatment? If yes, explain. | | | ✓ | ✓ |

| COMMUNITY CONTEXTS (continued) | L | E | M | N |
|---|---|---|---|---|
| Have any factors (law enforcement referral patterns, waiting lists, treatment funding slot capacity, access to treatment at other local programs, program outreach, media attention, availability, purity, overdoses just prior to treatment, withdrawal just prior to treatment, adulterants, route of administration, other drugs used concurrently, other drugs used by clients, other) contributed to increases or decreases in your program''s number of admissions related to any specific drug? If yes, describe. | | | ✓ | ✓ |
| Have any legal issues (nonviolent offenses, violent offenses, gang-related activity, prostitution, drug-assisted rape, domestic violence, DUI/DWI, other) increased or decreased as concerns among your clients since the last reporting period? If yes, describe. | | | ✓ | ✓ |
| **TREATMENT BACKGROUND** | | | | |
| What is your program's maximum capacity? | | | ✓ | ✓ |
| What is your current enrollment? | | | ✓ | ✓ |
| Does your program's clientele reflect the population of your local community? If no, please describe. | | | ✓ | ✓ |

**SPECIAL TOPIC: SYNTHETIC OPIOIDS**

All the above topics in "the drug," "the sale," and "the users: predominant characteristics" section were discussed about diverted/abused synthetic opioids (specify). In addition, the following topics were discussed:

| | L | E | M | N |
|---|---|---|---|---|
| How serious is the problem in your community? | ✓ | ✓ | ✓ | ✓ |
| How has the problem in your community changed since the last reporting period? | ✓ | ✓ | ✓ | ✓ |
| What are the sources of illicit distribution of the drug? | ✓ | ✓ | | |
| Are there a substantial number of impaired health care professionals using the drug in your community? If yes, explain. | | ✓ | ✓ | ✓ |
| Is the drug continually on the illicit drug market or does it emerge periodically? | ✓ | ✓ | | |
| Is there prevalence for opioid-naive adolescents in your community? If yes, explain. | | ✓ | ✓ | ✓ |
| Are highly tolerant or experienced opioid abusers using? If yes, explain. | | ✓ | ✓ | ✓ |
| Is the drug used to replace heroin, used with heroin, or is its use not associated with heroin use? | | ✓ | ✓ | ✓ |
| Is the user population in your community new this reporting period? | | ✓ | ✓ | ✓ |
| In your opinion, has the media overemphasized, underplayed, or reflected accurately the problem in your community? | ✓ | ✓ | ✓ | ✓ |
| Have there been any related health consequences, comorbidity/dual diagnoses, barriers to treatment, or legal issues related to the drug's abuse? | | | ✓ | ✓ |

*[L]Law enforcement*
*[E]Epidemiologic/ethnographic*
*[M]Methadone treatment*
*[N]Non-methadone treatment*
**Please note that for the methadone and non-methadone treatment interviews, "community" was replaced with "program."*
***Respondents were asked about heroin, crack cocaine, powder cocaine, methamphetamine, marijuana, ecstasy, GHB, ketamine, Rohypnol, hallucinogens (specify), and any other drugs (specify) for each of the discussion areas.*